INSTRUCTIONS TO AUTHORIZE ORAL DISCLOSURE OF PROTECTED HEALTH INFORMATION

The **AUTHORIZATION FOR ORAL DISCLOSURE OF PROTECTED HEALTH INFORMATION** form is used to orally disclose member health information to a person or organization designated by the member or the member's personal representative to discuss the member's health information.

The **AUTHORIZATION FOR ORAL DISCLOSURE OF PROTECTED HEALTH INFORMATION** form can be revoked at any time by written or emailed request to Commonwealth Care Alliance (CCA) Health Information Management Department.

For questions about the AUTHORIZATION FOR ORAL DISCLOSURE OF PROTECTED HEALTH INFORMATION:

Call the Health Information Management Department Monday – Friday 8am – 4:30pm at 877-769-3499 or email: HIM@commonwealthcare.org.

INSTRUCTIONS TO COMPLETE THE AUTHORIZATION FOR ORAL DISCLOSURE OF PROTECTED HEALTH INFORMATION FORM:

Section 1: Member Information

- Print the member's name, CCA member identification (ID) number, date of birth, address, phone number and email address, if applicable.

Section 2: **Permission to Orally Disclose Member Health Information**

- Print the name, address, phone number, and email address of the Person/Organization you designate to receive the oral disclosure.
- Indicate the topic of health information intended to be discussed. For example: "My medications list." Or "Answer all questions asked."
- Indicate the time frame or date of service for the member health information that will be discussed.

Section 3: Sensitive Information

- If you want certain sensitive information to be discussed, you must initial the box, otherwise it will not be disclosed.

Section 4: Expiration and Revocation

Indicate the date you want this authorization to expire or the event upon which it will expire. Unless otherwise revoked, this authorization will be valid for the member's enrollment term with CCA.

Section 5: Signature

If you are the member, sign and date in the spaces provided. If you are signing this authorization as Personal Representative, print your name in the space, phone number, and email. Check the box that describes your legal authority to release health information on behalf of the member and provide supporting documentation.

Examples of acceptable documents include:

- Attorney: Evidence that you are the Member's attorney
- Guardian/Conservator: Probate court order/decree
- Health Care Agent: Copy of invoked health care proxy and proof of being invoked.
- HIPAA Agent/Representative: Attach copy of HIPAA release/authorization form.
- Representative of Estate/Executor: Copy of appointment letters from probate court
- Power of Attorney (POA): POA that includes authority to use/disclose health information.
- Other Advocate: Document that explains your legal authority and relationship.

Submit the completed Oral Disclosure form to:

Commonwealth Care Alliance, Inc.,
Health Information Management
2 Avenue De Lafayette, 5th Floor
Boston, MA 02111

Fax: 413-733-1924

Email: HIM@commonwealthcare.org

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Los miembros deben llamar al 866-610-2273 (TTY 711).

You can get this document for free in other formats, such as large print, braille, or audio. Call 866-610-2273 (TTY 711). We are open 8 am to 8 pm, 7 days a week. The call is free.

Notice of Nondiscrimination

Commonwealth Care Alliance, Inc.® complies with applicable Federal civil rights laws and does not discriminate on the basis of, or exclude people or treat them differently because of, medical condition, health status, receipt of health services, claims experience, medical history, disability (including mental impairment), marital status, age, sex (including sex stereotypes and gender identity), sexual orientation, national origin, race, color, religion, creed, public assistance, or place of residence. Commonwealth Care Alliance, Inc.:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Member Services.

If you believe that Commonwealth Care Alliance, Inc. has failed to provide these services or discriminated in another way based on medical condition, health status, receipt of health services, claims experience, medical history, disability (including mental impairment), marital status, age, sex (including sex stereotypes and gender identity), sexual orientation, national origin, race, color, religion, creed, public assistance, or place of residence, you can file a grievance with:

Commonwealth Care Alliance, Inc.
Civil Rights Coordinator
30 Winter Street, 11th Floor
Boston, MA 02108
Phone: 617-960-0474, ext. 3932 (TTY 711) Fax: 857-453-4517
Email: civilrightscoordinator@commonwealthcare.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
Phone: 800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.