commonwealth care alliance®

# AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION FORM

*NOTE: This form does not authorize health care decision-making authority*

## 1. Member Information

| **Name:** _____ *Last Name, First Name, Middle Initial* | **Date of Birth:** ____/____/____ | **CCA ID:** _____ |
|---|---|---|

**Address:** _____

*Street Address* *City* *State* *Zip Code*

**Phone:** _____-_____-_____ **Email Address:** _____

## 2. Permission to Obtain/Disclose Member Health Information

**Obtain From** (The records will be uploaded and included in your Commonwealth Care Alliance, Inc. (CCA) chart once received):

Name: _____

Address: _____

_____

Phone: _____-_____-_____

Email Address: _____

**Disclose To:**

Name: _____

Address: _____

_____

Phone: _____-_____-_____

Email Address: _____

Description: ☐ Full or ☐ Partial Record – If Partial, describe the health records or information needed:

_____

☐ For this time frame: ____/____/____ **TO**: ____/____/____

Purpose: ☐ At the request of the member/other individual ☐ Other: _____

In the form of: ☐ Written ☐ Electronic/Paper Copies by: ☐ Fax ☐ Email ☐ Delivery or Pick-up

3. Sensitive Information: You must initial each box below in order for CCA to orally disclose this sensitive information.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Abortion** | | | **Domestic Violence** | | | **Physical Abuse** | |
| **AIDS/ARC** | | | **Gender-Affirming Care** | | | **Reproductive Health** | |
| **Alcohol & Substance Use** | | | **Genetic Testing** | | | **Sexually Transmitted Infection** | |
| **Behavioral Health** | | | **HIV** | | | | |

4. Expiration and Revocation

This AUTHORIZATION completed to "DISCLOSE" copies of CCA records will expire one year unless revoked. This AUTHORIZATION completed to "OBTAIN" records, unless otherwise revoked is valid for the member's enrollment term with CCA or as specified: ☐ On this date:_____/_____/_____ OR Event: _____

5. Signature: The signature below is my own and I am legally authorized to sign this document.

**Member/ Personal Representative* Signature:** _____Date: ____/____/____

**Print your name, phone number, and email below. Check (✓) the box that shows your legal authority under law to sign this form on the member's behalf.* ***Please return this completed form with supporting documentation.***

**Print Personal Representative Full Name:** _____

**Phone:** _____-_____-_____ **Email:** _____

☐ Attorney ☐ Guardian/Conservator ☐ Health Care Agent ☐ HIPAA Agent/Representative

☐ Representative of Estate/Executor ☐ Power of Attorney ☐ Other Advocate

I understand that the health information disclosed pursuant to this Authorization may be re-disclosed by the recipient and may no longer be protected by law. I have the right to revoke this Authorization in writing at any time by sending written revocation to the address below. I understand that my treatment, payment, enrollment in the health plan or eligibility for benefits does not depend on my signing this Authorization. The entity that seeks this Authorization must provide me with a copy of this signed form.

Please mail, fax, or email as indicated below.
For questions call Member Services at: 866-610-2273 (TTY 711), 8 am to 8 pm, 7 days a week.

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**Email: HIM@CommonwealthCare.org**