commonwealth care alliance

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

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 CCA chart once received):

Name:

_____

Address:

_____

_____

Phone:_____

Fax: _____

Email Address:

_____

Disclose To:

Name:

_____

Address:

_____

_____

Phone:_____

Fax: _____

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 request/release this sensitive information

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

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: ☐ 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

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