CareSource
Just4Me™

# PERMISSION TO SPEAK TO CARESOURCE ON MY BEHALF

## (AUTHORIZED REPRESENTATIVE) – *For members age 18 and older*

This form allows members to pick an individual ("authorized representative") to speak to CareSource on their behalf. Once the form is completed, please send it to the CareSource Privacy Officer by mail to CareSource, P.O. Box 8738, Dayton, OH 45401-8738 or fax to 937-425-0907.

Member Name: _____ Member Address: _____

Member City, State, Zip Code: _____

Member Phone: _____ Member ID #: _____ Member Date of Birth: _____

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I approve _____ to speak to CareSource on my behalf.
Member's Authorized Representative

This permission (check one): ☐ ends on _____.

☐ has no end date.

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**By signing my name, I agree:**

I understand that CareSource may share information about my health with my Authorized Representative. I understand that my Authorized Representative may share my information with others. This information may not be protected by federal or state law.

I understand that this form is not a Health Care Power of Attorney and it does not permit anyone to make decisions about my health care treatment, services or procedures. I do not have a Healthcare Power of Attorney or Guardianship established for someone to make these decisions.

I know that I can change my mind at any time by sending something in writing. This written letter should be sent to: Privacy Officer, CareSource, PO Box 8738, Dayton, OH 45401-8738. Email: hipaaprivacyofficer@caresource.com. Fax: 937-425-0907.

_____
Member Signature

_____
Member Printed Name

_____
Date