Beneficiary Consent/HIPAA Authorization Form

This form allows CareSource Military & Veterans™ (CSMV) to share your health information and explains how we may do so. Complete all sections of this form and mail or fax it to the address provided at the end. You also have the choice to fill out this form online at **CareSourceMilitary.com**.

Section 1: Beneficiary Information

Last Name	MI	First Name	Date of Birth
Street Address	City	State	Zip Code
Home Phone	Cell Phone	ID Number (Found on ID Card)	
By providing your cell phone number, you consent to CSMV using it to contact you.			

Section 2: Consent to Share Health Information

Complete this section to authorize us to share your health care information with others. We share health care information to help with your care and treatment. We also share it to help facilitate benefits. We may share your health care information with:

- Any past, current, or future providers you have consulted for care.
- Certain Health Information Exchanges (HIE) that allow providers to access health information from CSMV.

You also have the option to share your health information through your personal health care apps. You can ask for a list of everyone with whom we shared your health information.

☐ Check this box if you want to share your health information with past, current and future providers, or with your personal health care apps. CSMV will share this information to assist with your care and benefits, including sensitive health information related to substance use and HIV/AIDS. You will have greater control over the information shared when you use personal health care apps.

Or

☐ Check this box if you **do not** want* your health care information shared with your past, current or future providers. It will not be shared with your providers except:

- Your provider may see the physical and behavioral health treatment you have received. We will not share treatment for substance use or HIV/AIDS.
- Your health care information may be shared with an HIE. We will not share treatment for substance use or HIV/AIDS.

**If you do not allow sharing, your providers may not manage your care as effectively as they could with your consent.*

Section 3: Representative Designation
Complete this section if you wish to appoint someone to communicate with CSMV on your behalf. CSMV will share all of your health information with the named individual. If you name a group, like a law firm, the group is called an entity. Please provide their name and a contact person.

Last Name	First Name	MI	Entity Name (if law firm or other entity)
Street address	City	State	Zip Code
Home Phone		Cell Phone	

Section 4: Review and Approval
By signing my name, I agree:

To allow CSMV to share my health information as noted in Sections 2 and/or 3. I understand that signing this form is my choice. I acknowledge that the information shared may be further shared by the recipient, potentially losing its protection under federal privacy laws. Information related to substance use disorder from specific treatment programs (42 CFR Part 2) will remain confidential and cannot be shared again without my permission. I understand this form does not create a Health Care Power of Attorney.

I understand that I can revoke this permission at any time. I can revoke permission by sending a written request to CSMV at the address at the end of this form or by faxing it to the number listed. I may also cancel my permission online at **CareSourceMilitary.com**. I understand that revoking this permission will not affect any actions CSMV took before my cancellation. My treatment, payment, enrollment, or eligibility for benefits will not depend on whether I sign this form. Please sign on the next page.

Beneficiary/Minor Beneficiary's Parent Signature or Designated Legal Representative Signature*:	Date:

If you do not give a date, the permission will stay in effect unless you request cancellation. For minors, the permission will end on their 18th birthday.

be a designated legal representative. You must provide proof of their authority to act on behalf

		Power of Attorney, Court-Appointed Guardian or Custodian):	
Representative's Street Address			

Please send your completed form to us using one of the following methods:

Mail: CareSource
Attn: Privacy Officer
P.O. Box 8738
Dayton, OH 45401-8738
Fax: 1-833-334-4722
Online: CareSourceMilitary.com

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