HAP CareSource™

Member Consent/HIPAA Authorization Form

This form lets HAP CareSource™ MI Coordinated Health (HMO D-SNP) share your health care information as described below. All of this form must be filled out. Mail or fax it to the address listed at the end of this form. You may also fill out this form online at **HAPCareSource.com**.

Section 1: Your Information

Last Name	MI	First Name	Date of Birth
Street Address	City	State	Zip Code
Phone Number		Member ID Number	

By giving your cell phone number, you are saying that HAP CareSource MI Coordinated Health may use it to reach you.

Section 2: Consent

This form gives your consent to share your health care information with others or on your own health care apps. It may be shared with your past, current, or future providers. It also may be shared with Health Information Exchanges (HIE). An HIE lets providers view the health care information that HAP CareSource MI Coordinated Health has about you. You can ask for a list of people who were given your health care information by HAP CareSource MI Coordinated Health.

- ☐ Check this box if you want your health care information shared with your past, current, or future providers or on health care apps. It will be shared for treatment, to manage your care, and to help with benefits. It includes sensitive health information. This includes treatment for substance use and HIV/AIDS. You have more control over what is shared on 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. Treatment for substance use or HIV/AIDS will not be shared.

- Your health care information may be shared with a HIE. Treatment for substance use or HIV/AIDS will not be shared.

** Your providers may not be able to care for you as well as they could if you do not approve sharing.*

Section 3: Representative Designation

Fill out the lines below to name someone that HAP CareSource MI Coordinated Health can speak to on your behalf. Your health care information will also be shared with this person.

Your Representative

Last Name	MI	First Name	Date of Birth
Entity Name (if law firm or other)			
Street Address	City	State	Zip Code
Phone Number			

Section 4: Review and Approval

By signing my name, I agree: To let HAP CareSource MI Coordinated Health MyCare Ohio share my health care information as marked in Sections 2 and/or 3. The person or entity receiving the health care information could share it again. Federal privacy laws may no longer protect it. Treatment for substance use is private and cannot be shared again without my permission.

Signing this form is my choice. I may cancel this consent at any time. I must send a written letter to HAP CareSource MI Coordinated Health to cancel. I may mail or fax the letter to the address at the bottom of this form. I may also cancel on **HAPCareSource.com**. Cancelling this consent will not change the actions HAP CareSource MI Coordinated Health took before I cancelled. My treatment, payment, enrollment or benefits do not depend on whether I sign this form. **Please sign below.**

Your Signature (Parent/Guardian for Minors or Legal Representative*)	Date:
Date this Consent Ends: Consent ends on the date above or when a minor turns 18 years old. It does not end if no date is given.	

**You must have a copy of the Power of Attorney or court papers if this is signed by a legal representative. The lines below must also be filled out.*

Legal Representative

First and Last Name		Choose one: ☐ Power of Attorney ☐ Court-Appointed Guardian or Custodian ☐ Other:	
Street Address	City	State	Zip Code

Please send this form to:

Mail: HAP CareSource
Attn: Privacy Office
P.O. Box 8738
Dayton, OH 45401-8738

Fax: 1-833-334-4722 (TTY: 711)
Online: **HAPCareSource.com**

MDHHS Michigan Department of Health & Human Services | MI Coordinated Health