



Member Consent/HIPAA Authorization Form

This form lets CareSource Management Group Co. and its affiliated health plans (“CareSource”), share your health 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. Or, you may choose to fill out this form online at www.caresource.com.

Section 1: Member Information

Member Last Name	MI	Member First Name	Member Date of Birth
Member Street Address	City	State	Zip Code
Member Home Phone	Member Cell Phone	Member ID Number (Found on Plan ID Card)	
<i>By giving your cell phone number, you are saying that CareSource may use it to contact you.</i>			

Section 2: Consent to Share Health Information

CareSource believes it is important that you agree to share your health information. This information is shared to handle your care and treatment or to help with benefits. It will be shared with your past, current, and future treating providers. It also will be shared with the Health Information Exchanges (HIE). An HIE lets providers view health information that CareSource has about members. You have the right to ask for a list of everyone who was given your health information by CareSource.

- Check this box if you want your health information to be shared with past, current, and future treating providers. The information will be shared for treatment, to manage your care and to help with benefits. Your health information to be shared will include sensitive health information, including treatment for substance use and HIV/AIDS.

Or –

- Check this box if you **do not want** your health information to be shared with past, current, and future treating providers. The information will not be shared for treatment, to manage your care or to help with benefits. None of your health information will be shared with your providers, with these exceptions:
- Due to state requirements we must follow, your Primary Care Provider (PMP) will receive a report that includes physical and behavioral health treatment information you may have received. It will not include substance use or HIV/AIDS information unless you checked the box above saying you want to share your health information.
 - Due to other requirements we must follow, your health information will be shared with the HIE. It will not include substance use or HIV/AIDS information unless you checked the box above saying you want to share your health information.

If you do not approve sharing, all providers helping care for you may not be able to manage your care as well as they could if you did approve sharing.

Section 3: Representative Designation

If you would like to name someone that CareSource may speak to on your behalf, please fill out this section. CareSource will share all of your health information with the person you name. If you name a group, like a law firm, the group is called an entity. Please give the entity's information and the name of a contact person at the entity.

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 let CareSource share my health information as marked in Sections 2 and/or 3. I agree that signing this form is my choice. I agree the information shared could be shared again by the person or entity receiving it. After that it may no longer be protected by federal privacy laws. Substance use disorder information from specific treatment programs (42 CFR Part 2) may be kept private and not allowed to be shared again without my permission. I agree this form is not making a Health Care Power of Attorney. I agree that I may cancel this permission at any time. To cancel permission, I must send a written letter to CareSource. I can send the letter to the address at the bottom of this form. I can also fax it to the number at the bottom of this form. Or, I may cancel my permission on www.caresource.com. I agree that if I cancel this permission, it will not change any actions CareSource took before I cancelled permission. I agree that my treatment, payment, enrollment or eligibility for benefits do not depend on signing this form. **Please sign below.**

Member/Minor Member's Parent Signature or Designated Legal Representative Signature*:		Date:	
Date this Permission Ends: <i>If no date given, the permission will remain on your record unless/until you ask us to cancel it. For minor members, it will end on their 18th birthday.</i>			
<i>*If signed by someone other than the member/minor member's parent, that person must be a designated legal representative. A designated legal representative is someone who has been given the authority to act on the behalf of the member. If you have not already done so, you must provide a copy of the Power of Attorney or court papers that prove the person is a designated legal representative. Also complete these fields:</i>			
Legal Representative (print full name)	Legal Relationship to Member, e.g., Power of Attorney, Court-Appointed Guardian or Custodian:		
Legal Representative's Street Address	City	State	Zip Code

Please send your completed form to:

CareSource/ Attn: Privacy Office, P.O. Box 8738, Dayton, OH 45401-8738, **or**,
 Fax it to 1-833-334-4722, **or**,
 you may fill out this form online at www.caresource.com.

If you, or someone you're helping, have questions about CareSource, you have the right to get help and information in your language at no cost. Please call the member services number on your member ID card.

ARABIC

إذا كان لديك، أو لدى أي شخص تساعد، أية استفسارات بخصوص CareSource، فيحق لك الحصول على مساعدة ومعلومات مجاناً وباللغة التي تتحدث بها. للتحدث إلى أحد المترجمين الفوريين، رجي الاتصال على رقم خدمة الأعضاء الموجود على بطاقة تعريف العضو الخاصة بك.

AMHARIC

እርስዎ፣ ወይም እርስዎ የሚያግዙት ግለሰብ፣ ስለ CareSource ጥያቄ ካላችሁ፣ ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። ከአስተርጓሚ ጋር እባክዎን በመታወቂያ ካርዱ ላይ ባለው የአገልግሎቶች ቁጥር ይደውሉ።

BURMESE

CareSource အကြောင်း သင် သို့မဟုတ် သင်အကူအညီပေးနေသူ တစ်စုံတစ်ယောက်က မေးမြန်းလာပါက သင်ပြောဆိုသော ဘာသာစကားဖြင့် အကူအညီနှင့် အချက်အလက်များအား အခမဲ့ ရယူနိုင်ရန် အခွင့်အရေးရှိပါသည်။ ဘာသာပြန်တစ်ဦးအား ရွေးချယ်၍ ပြော သင်္ကြန် အသံဖြင့် ငြိကြက်ပေါ်ရှိ အသံဖြင့် ငြိ ဝက်စ ငြိငြိငြိမူဝက်ရုံနံကံသို့ သို့မဟုတ် ခေါ်ဆိုပါ။

CHINESE

如果您或者您在帮助的人对 CareSource 存有疑问，您有权免费获得以您的语言提供的帮助和信息。如果您需要与一位翻译交谈，请拨打您的会员 ID 卡上的会员服务电话号码。

CUSHITE – OROMO

Isin yookan namni biraa isin deeggartan CareSource irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, Maaloo lakkoofsa bilbilaa isa waraqaa eenyummaa keessan irra jiruun tajaajila miseensaatii bilbilaa.

DUTCH

Als u, of iemand die u helpt, vragen heeft over CareSource, hebt u het recht om kosteloos hulp en informatie te ontvangen in uw taal. Als u wilt spreken met een tolk. Bel naar het nummer voor ledendiensten op uw lidkaart

FRENCH (CANADA)

Des questions au sujet de CareSource? Vous ou la personne que vous aidez avez le droit d'obtenir gratuitement du soutien et de l'information dans votre langue. Pour parler à un interprète. Veuillez communiquer avec les services aux membres au numéro indiqué sur votre carte de membre.

GERMAN

Wenn Sie, oder jemand dem Sie helfen, eine Frage zu CareSource haben, haben Sie das Recht, kostenfrei in Ihrer eigenen Sprache Hilfe und Information zu bekommen. Um mit einem Dolmetscher zu sprechen, Bitte rufen Sie die Mitglieder-Service Nummer auf Ihrer Mitglieder-ID-Karte an

GUJARATI

જો તમે અથવા તમે કોઈને મદદ કરી રહ્યાં તમે ઈથી કોઈને CareSource વિશે પ્રશ્નો હોય તો તમને મદદ અને મહત્વની માહિતીનો અધિકાર છે. તે અર્થે વિન તમ રી ભ ય મ ઈ ય પત કરી શક ર છે. દ ભ વપરો િત કરિ મ ટે,કૃપા કરીને તમારા સભ્ય આઈડી કાર્ડ પર સભ્ય સેવા માટે ના નંબર પર ફોન કરો.

HINDI

यदि आपके, या आप जिसकी मदद कर रहे हैं उसके CareSource के बारे में कोई सवाल हैं तो आपके पास बगैर किसी लागत के अपनी भाषा में सहायता और जानकारी प्राप्त करने का अधिकार है। एक दुभाषिए से बात करने के लिए कॉल करें, कृपया अपने सदस्य आईडी कार्ड पर दिये सदस्य सेवा नंबर पर कॉल करें।

ITALIAN

Se Lei, o qualcuno che Lei sta aiutando, ha domande su CareSource, ha il diritto di avere supporto e informazioni nella propria lingua senza alcun costo. Per parlare con un interprete. Chiamare il numero dei servizi ai soci riportato sulla tessera di iscrizione.

JAPANESE

ご本人様、または身の回りの方で、CareSource に関するご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます (無償)。通訳をご利用の場合は、お持ちの会員IDカードにある、会員サービスの電話番号までお問い合わせ下さい。

KOREAN

귀하 본인이나 귀하께서 돕고 계신 분이 CareSource에 대해 궁금한 점이 있으시면, 원하는 언어로 별도 비용 없이 도움을 받으실 수 있습니다. 통역사가 필요하시면 다음 번호로 전화해 귀하의 회원 ID 카드에 적힌 회원 서비스 팀 번호로 전화하십시오.

PENNSYLVANIA DUTCH

Wann du hoscht en Froog, oder ebber, wu du helpscht, hot en Froog baut CareSource, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griegie, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, Bel alstublieft met het Ledenservice nummer op uw lid ID -kaart.

RUSSIAN

Если у Вас или у кого-то, кому Вы помогаете, есть вопросы относительно CareSource, Вы имеете право бесплатно получить помощь и информацию на Вашем языке. Для разговора с переводчиком. Пожалуйста, позвоните по телефону отдела обслуживания клиентов, указанному на вашей идентификационной карточке клиента.

SPANISH

Si usted o alguien a quien ayuda tienen preguntas sobre CareSource, tiene derecho a recibir esta información y ayuda en su propio idioma sin costo. Para hablar con un intérprete. Por favor, llame al número de Servicios para Afiliados que figura en su tarjeta de identificación.

UKRAINIAN

Якщо у вас, чи в особи, котрій ви допомагаєте, виникнуть запитання щодо CareSource, ви маєте право безкоштовно отримати допомогу та інформацію вашою мовою. Щоб замовити перекладача, Зателефонуйте за номером обслуговування учасників, який вказано на вашому посвідченні учасника

VIETNAMESE

Nếu bạn hoặc ai đó bạn đang giúp đỡ, có thắc mắc về CareSource, bạn có quyền được nhận trợ giúp và thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên. Vui lòng gọi số dịch vụ thành viên trên thẻ ID thành viên của bạn.

CareSource complies with applicable state and federal civil rights laws and does not discriminate on the basis of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status. CareSource does not exclude people or treat them differently because of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status.

CareSource provides free aids and services to people with disabilities to communicate effectively with us, such as: (1) qualified sign language interpreters, and (2) written information in other formats (large print, audio, accessible electronic formats, other formats). In addition, CareSource provides free language services to people whose primary language is not English, such as: (1) qualified interpreters, and (2) information written in other languages. If you need these services, please call the member services number on your member ID card.

If you believe that CareSource has failed to provide the above mentioned services to you or discriminated in another way on the basis of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status, you may file a grievance, with:

CareSource
Attn: Civil Rights Coordinator
P.O. Box 1947, Dayton, Ohio 45401
1-844-539-1732, TTY: 711
Fax: 1-844-417-6254

CivilRightsCoordinator@CareSource.com

You can file a grievance by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office of Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F
HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.