



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

The CareSource policy is to share your health information. This includes Sensitive Health Information (SHI). SHI can be information related to drug and/or alcohol treatment, genetic testing results, HIV/AIDS, mental health, sexually transmitted diseases (STD), or communicable/other diseases that are a danger to your health. This information is shared to handle your care and treatment or to help with benefits. This info is shared with your past, current, and future treating providers. It also is shared with 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.

If you do not want your health information (including SHI) to be shared for treatment, to manage your care and help with benefits, check here:

If you check the box above, none of your health information (including SHI) will be shared. It will not be shared with your providers. (It will be shared with the provider who treats you for the specific SHI.) If you do not approve sharing, all providers helping care for you may not be able to manage your care as well as if 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 info 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 may be subject to being 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 whether I sign 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 choose to fill out this form online at www.caresource.com.

CareSource® MyCare Ohio (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Ohio Medicaid to provide benefits of both programs to enrollees.

If you speak English, language assistance services, free of charge, are available to you. Call 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. to 8 p.m. The call is free.

Si habla español, tiene disponible los servicios de asistencia de idioma gratis. Llame al 1-855-475-3163 (TTY: 1-800-750-0750 o 711), de lunes a viernes, de 8 a.m. a 8:00 p.m. La llamada es gratuita.



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CMS/ODM Approved 5/7/2018

ENGLISH

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-475-3163 (TTY: 1-800-750-0750).

SPANISH

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-475-3163 (TTY: 1-800-750-0750).

CHINESE

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-475-3163 (TTY: 1-800-750-0750)。

GERMAN

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-475-3163 (TTY: 1-800-750-0750).

ARABIC

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-475-3163 (رقم هاتف الصم والبكم: 1-800-750-0750).

PENNSYLVANIA DUTCH

Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-855-475-3163 (TTY: 1-800-750-0750).

RUSSIAN

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-475-3163 (телетайп: 1-800-750-0750).

FRENCH

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-475-3163 (ATS : 1-800-750-0750).

VIETNAMESE

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-475-3163 (TTY: 1-800-750-0750).

CUSHITE/ROMO

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-855-475-3163 (TTY: 1-800-750-0750).

KOREAN

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-475-3163 (TTY: 1-800-750-0750) 번으로 전화해 주십시오.

ITALIAN

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-475-3163 (TTY: 1-800-750-0750).

JAPANESE

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-475-3163 (TTY:1-800-750-0750) まで、お電話にてご連絡ください。

DUTCH

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-855-475-3163 (TTY: 1-800-750-0750).

UKRAINIAN

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-855-475-3163 (телетайп: 1-800-750-0750).

ROMANIAN

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-855-475-3163 (TTY: 1-800-750-0750).

NEPALI

ध्यान दिनुहोस्: तपाइंले नेपाली बोलनुहुन्छ भने तपाइंको नमिति भाषा सहायता सेवाहरु नःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-855-475-3163 (टटिवाइ:1-800-750-0750) ।

SOMALI

DIGTOONI: Haddii aad ku hadasho Af Soomaali, adeegyada caawimada luqada, oo lacag la'aan ah, ayaa lagu heli karaa adiga. Wac 1-800-475-3163 (TTY: 1-800-750-0750).


CareSource[®]

CareSource[®] MyCare Ohio
(Medicare-Medicaid Plan)

Notice of Non-Discrimination



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 contact CareSource at 1-855-475-3163 (TTY: 1-800-750-0750 or 711).

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>.