PERMISSION TO SPEAK TO CARESOURCE / HIPAA AUTHORIZATION FORM

This form lets CareSource Management Group Co. and those health plans for which it is the sole or special member ("CareSource") to give your Protected Health Information to the person or entity you list below. Please fill in the form and then mail it to the CareSource Privacy Office at CareSource, P.O. Box 8738, Dayton, OH 45401-8738, or fax it to 937-425-0907.

Member Name: _____

Member Address: _____

Member City, State, Zip Code: _____

Member Phone: _____ Member ID #: _____

Member Date of Birth: _____

I let CareSource® MyCare Ohio (Medicare-Medicaid Plan) give out the following to assist in my health care and payment of my health care (check one). If you only want information from certain dates to be given, please write in those dates:

☐ All information: _____

☐ My medical information: _____

☐ My payment information: _____

Disclosures Requiring Special Authorization. By marking below, I specifically permit giving out my protected health information about the following:

☐ Mental Health or Chemical Dependency
☐ Substance Abuse (Drug/Alcohol Treatment)
☐ HIV/AIDS Testing or Treatment
☐ Sexually Transmitted Diseases

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I want the information listed above to be given out by CareSource to assist in obtaining quality health care and payment of my health care. I want this information to be given to:

Name of Person or Entity: _____

Person or Entity's Full Address: _____

Person or Entity's Phone Number: _____

Person or Entity's Fax Number: _____

This permission (check one): ☐ has no end date.
☐ ends on _____ (give date).

By signing my name, I agree that:

I let CareSource share information about my health with the person/entity named by me above. I understand that signing this form is voluntary. I understand the information given out may be subject to being given out again by the person or entity receiving it. I understand this form is not creating a Health Care Power of Attorney. I understand that I may cancel this permission at any time. To cancel permission, I must send a letter in writing to the HIPAA Privacy Office, at CareSource, P.O. Box 8738, Dayton, OH 45401-8738. Email: HIPAAPrivacyOfficer@CareSource.com. Fax: 937-425-0907. I understand that if I cancel this authorization, it will not have any effect on any actions CareSource took before I cancelled permission. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this form.

	OR	
_____		_____
Member Signature		Authorized Representative Signature
_____		_____
Member Printed Name		Authorized Representative Printed Name and Date
_____		_____
Date		Description of Authorized Representative's Authority to Act on Member's Behalf

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.

You can get this information for free in other languages. Call 1-855-475-3163. The call is free. Puede obtener esta información de forma gratuita en otros idiomas. Llame al 1-855-475-3163. La llamada es gratuita.

MyCareOhio
Connecting Medicare + Medicaid