HIPAA AUTHORIZATION FORM

This form lets CareSource Management Group Co. and its affiliated health plans ("CareSource"), share your Protected Health Information (PHI) as described below. This form must be filled out completely. Mail it to: CareSource, Attn: Privacy Office, P.O. Box 8738, Dayton, OH 45401-8738. Or you can fax it to 937-425-0907.

Member Name: First, Middle Initial, Last | *Member Date of Birth*

Member Address, City, State, Zip

Member Phone: ☐ *Home* ☐ *Cell* | *Member ID # (found on plan ID card):*

If you give your cell number, it is understood that we can use it to call the member.

You can approve all PHI records to be used. If you want information from certain dates to be given, please write in those dates. Please check the best box:

☐ All records

☐ All records from: _____ (begin date) through _____ (end date)

☐ Other: _____

I understand that my health record may have information about acquired immunodeficiency syndrome (AIDS). It may also have information about human immunodeficiency virus (HIV). It may also have information about behavioral or mental health services and sexually transmitted disease diagnosis/treatment. It may also have information about treatment for alcohol and drug abuse. It may also have information about psychiatric/psychological issues. If you do not want these types of records released, please check this box: ☐

I want the records listed above to be shared to assist in getting health care. The records can also be used for payment for my health care. Share this information with:

Name: First, Middle Initial, Last | *Relationship to member, e.g. parent, sibling, caregiver, attorney, etc.*

Address, City, State, Zip

Phone: ☐ *Home* ☐ *Cell* | *Date or event when permission ends:* ***Expiration date or expiration event is required***

-OVER-

Member information may be shared with the person named above. If a class of persons, e.g. law firm, please indicate that entity's information and include contact information for the responsible person at the entity.

By signing my name, I agree: I let CareSource share my health information with the person/entity named by me above. I understand that signing this form is my choice. I understand the information shared may be subject to being shared again by the person or entity receiving it, and it will no longer be protected by federal privacy laws. 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 CareSource at the address at the top of the form. I can also fax it to the number provided at the top of this form. 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.

Member Name (PRINT)	***Authorized Representative Name (PRINT)***
OR	
Member Signature Date	*Authorized Representative Signature Date*

**Authorized Representative Signature Date*

**If form is signed by someone other than the member, describe the Authorized Representative's authority to act on member's behalf. For example the Authorized Representative could be a parent of minor. Or it could be a court appointed guardian. If not already on record with us, a copy of the legal document showing guardianship, custody, etc., must be attached.*