Authorization to Use and Disclose Health Information

meridiancomplete

Notice to Member:

- Completing this form will allow MeridianComplete to (i) use your health information for a particular purpose, and/or (ii) share your health information with the individual or entity that you identify on this form.
- You do not have to give permission to use or share your health information. Your services and benefits with Wellcare will not change if you do not submit this form.
- If you want to cancel this authorization form, send us a written request to revoke it at the address on the bottom of this page. A revocation form can be provided to you by calling Member Services at the phone number on the back of your member ID card.
- Wellcare cannot promise that the person or group you allow us to share your health information with will not share it with someone else.
- Keep a copy of all completed forms that you send to us. We can send you copies if you need them.
- If you need help, contact Member Services at the phone number on the back of your member ID card.
- Fill in all the information on this form. When finished, mail the form and any supporting documentation to

MeridianComplete
ATTN: Compliance Department
1 Campus Martius, Suite 700
Detroit, MI 48226

Aviso al (la) afiliado(a):

- Al llenar este formulario, usted autoriza a Wellcare a (i) que use su información de salud para un fin en particular, y/o (ii) que la dé a conocer a la persona o entidad que usted identifique en este formulario.
- Usted no tiene que firmar este formulario ni dar permiso a usar o dar a conocer su información de salud. Sus servicios y beneficios de Wellcare no cambiarán si usted no firma este formulario.
- Si desea cancelar este formulario de autorización, envíenos por escrito una solicitud para revocarlo a la dirección que aparece al final de esta página. Servicios para los afiliados puede proporcionarle un formulario de revocación si les llama al número telefónico que se encuentra en la parte trasera de su tarjeta de identificación de afiliación.
- Wellcare no puede prometer que la persona o el grupo al que nos permita dar a conocer su información de salud no la dará a conocer a alguien más.
- Conserve una copia de todos los formularios llenos que nos envíe. Si las necesita, podemos enviarle copias.
- Si necesita ayuda, comuníquese con Servicios para los afiliados al número telefónico que aparece en la parte trasera de su tarjeta de identificación de afiliación.
- Llene toda la información en este formulario. Al terminar, envíe el formulario y todos los documentos de apoyo a

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Detroit, MI 48226

PLEASE READ THE INSTRUCTIONS CAREFULLY AND COMPLETE THE FORM BELOW. INCOMPLETE FORMS CANNOT BE ACCEPTED.

1 **MEMBER INFORMATION:**

Member Name *(print)*: _____

Member Date of Birth: _____ Member ID Number: _____

2 **I GIVE WELLCARE PERMISSION TO USE MY HEALTH INFORMATION FOR THE PURPOSE IDENTIFIED OR TO SHARE MY HEALTH INFORMATION WITH THE PERSON OR GROUP NAMED BELOW. THE PURPOSE OF THE AUTHORIZATION IS** *(check one option below)***:**

☐ to allow Wellcare to help me with my benefits and services, **OR**

☐ to permit Wellcare to use or share my health information for _____

3 **PERSON OR GROUP TO RECEIVE INFORMATION** *(add more Persons or Groups on next page)***:**

Name (person or group): _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: (_____) _____ -_____

4 **I AUTHORIZE WELLCARE TO USE OR SHARE THE FOLLOWING HEALTH INFORMATION** *(NOTE: Select the first statement to release ALL health information or select the below statement to release only SOME health information. **Both CANNOT be selected.**)*

☐ **All of my health information INCLUDING:**
Genetic information, services or test results; HIV/AIDS data and records; mental health data and records (but not psychotherapy notes); prescription drug/medication data and records; and drug and alcohol data and records (please specify any substance use disorder information that may be disclosed);

OR

☐ **All of my health information EXCEPT** *(check only the boxes below that apply)***:**

- ☐ Genetic information, services or tests
- ☐ AIDS or HIV data and records
- ☐ Drug and alcohol data and records
- ☐ Mental health data and records (but not psychotherapy notes)
- ☐ Prescription drug/medication data and records
- ☐ Other: _____

5 **THIS AUTHORIZATION ENDS ON THIS DATE/EVENT:** _____
Date this authorization ends unless cancelled. If this field is blank, the authorization expires one year from the date of the signature below.

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6 **MEMBER OR LEGAL REPRESENTATIVE SIGNATURE:** _____

DATE: _____

IF LEGAL REPRESENTATIVE - Relationship to Member: _____
*If you are the Member's legal or personal representative, **you must send us copies of relevant forms**, such as power of attorney or order of guardianship.*

MAIL COMPLETED AUTHORIZATION FORM AND ANY SUPPORTING DOCUMENTATION TO
MeridianComplete ATTN: Compliance Department *1 Campus Martius, Suite 700 Detroit, MI 48226*

NOTE: If you are consenting to disclose any substance use disorder records to a recipient that is neither a third party payor nor a health care provider, facility, or program where you receive services

from a treating provider, such as a health insurance exchange or a research institution (hereafter, “recipient entity”), you must specify the name of an individual with whom or the entity at which you receive services from a treating provider at that recipient entity, or simply state that your substance use disorder records may be disclosed to your current and future treating providers at that recipient entity.

Name (individual or entity): ______________________________

Address: ______________________________

City: ______________ State: ________ Zip: ________ Phone: ( ) -

Name (individual or entity): ______________________________

Address: ______________________________

City: ______________ State: ________ Zip: ________ Phone: ( ) -

Name (individual or entity): ______________________________

Address: ______________________________

City: ______________ State: ________ Zip: ________ Phone: ( ) -

Name (individual or entity): ______________________________

Address: ______________________________

City: ______________ State: ________ Zip: ________ Phone: ( ) -

Name (individual or entity): ______________________________

Address: ______________________________

City: ______________ State: ________ Zip: ________ Phone: ( ) -

Name (individual or entity): ______________________________

Address: ______________________________

City: ______________ State: ________ Zip: ________ Phone: ( ) -

Name (individual or entity): ______________________________

Address: ______________________________

City: ______________ State: ________ Zip: ________ Phone: ( ) -

Name (individual or entity): ______________________________

Address: ______________________________

City: ______________ State: ________ Zip: ________ Phone: ( ) ___ - _______

ATTESTATION

I hereby attest that I have the ability to make medical decisions on behalf of:

MeridianComplete Member Name: _____

Member ID: _____ (if known)

Medicare Number: _____

Medicaid Number: _____

For example:

I am the court-appointed legal guardian, or I have a valid durable healthcare power of attorney, or I am able to make medical decisions under state surrogacy consent laws for the MeridianComplete Member.

I further confirm that documentation of this authority can be supplied upon request to the Centers for Medicare & Medicaid Services (CMS).

_____ _____

Representative Signature **Date**

My contact information is as follows:

Name (print): _____

Address: _____

Home phone: _____

Cellphone: _____ (optional)

Email: _____ (optional)

Preferred method of contact: _____

I wish plan correspondence, documents, benefit information, mailings, bills, etc., mailed to: (check one)

My address ☐ The Member's address ☐

Witness: (cannot be Representative, MeridianComplete member or person associated with healthcare facility)

Name_____ Date: _____
Name _____Date: _____