# AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

This authorization is voluntary and may be used to permit Community Health Choice (Community) to use or disclose an individual's protected health information (PHI).

Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their PHI.

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## **RIGHT TO REVOKE:**

I understand that I can withdraw my permission at any time by sending Community a letter via mail, email or fax, to the address listed at the end of this document. Your letter must also include the member's full name, member number, address, and phone number.

The authorization will have no effect on actions Community took in good faith before receiving a letter to withdraw authorization.



# WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

NAME	
MAILING ADDRESS	
CITY	ZIP CODE
DAY PHONE	OTHER PHONE
PLEASE SELECT THOSE THAT APPLY:	
Self	Legal Guardian
Natural or Adoptive Parent	Spouse
Foster Parent	Step-Parent
Legal Representative – someone with legal authority to act on the member's behalf	Other
	member, you must provide a copy of the health care power of ment that authorizes you to act on the members' behalf, and ED?
All Information described below	
Benefits, Billing, and Claim Information	Identification Card Request
Primary Care Provider Changes	Premium Payment
Home Address Changes	Name Spelling and other Personal Information
Your initials are required to release the following	information:
Mental Health Information	Pregnancy/Family Planning
Drug, Alcohol or Substance Abuse	HIV/AIDS
Genetic Information	

Please Note: There are limitations to the amount of information we are able to share with others in regards to your account. Note to parents: these limitations may not affect the legal rights you have to access your child's information by other means, like contacting your child's primary care physician.



#### **HIPAA STATEMENT:**

This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act. Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.

Covered entities, as the term is defined by HIPAA and Texas Health and Safety, must obtain a signed authorization from an individual or the individual's legally authorized representative to disclose that individuals Protected Health Information (PHI).

The Authorization provided by use of the form means the organization, entity or person authorized can disclose, communicate, or send named individuals PHI to the organization, entity or person identified on the form, including through use of any electronic means.

## **SIGNATURE AND AUTHORIZATION:**

I have read this form in its entirety and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of PHI that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities.

SIGNATURE:	DATE: / / /
Signature of In	dividual or Individual's Legally Authorized Representative
Printed name of legally Authorized Rep	resentatives (if applicable):
	for the release of certain types of information, including for example, the types of reproductive care, sexually transmitted diseases, and drug, alcohol, or atment:
SIGNATURE:	DATE: / / /

E-mail: MemberServices@CommunityHealthChoice.org

Fax: 713.295.2293 – Fulfillment Department

Mail: Community Health Choice

Attention: Fulfillment Department 2636 South Loop West, Suite 125

Houston, TX 77054

