# 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												
dutionty to det on the members bendin													
If the person signing this authorization is not the	e member, you must provide a copy of the health care power of ment that authorizes you to act on the members' behalf, and SED?												
If the person signing this authorization is not the attorney, birth certificate or other relevant documeroof of identity.	ment that authorizes you to act on the members' behalf, and												
If the person signing this authorization is not the attorney, birth certificate or other relevant document of identity.  WHAT INFORMATION CAN BE DISCLOS	ment that authorizes you to act on the members' behalf, and												
If the person signing this authorization is not the attorney, birth certificate or other relevant documents of identity.  WHAT INFORMATION CAN BE DISCLOS  All Information described below	ment that authorizes you to act on the members' behalf, and SED?												
If the person signing this authorization is not the attorney, birth certificate or other relevant documents of identity.  WHAT INFORMATION CAN BE DISCLOS  All Information described below  Benefits, Billing, and Claim Information	SED?  Identification Card Request												
If the person signing this authorization is not the attorney, birth certificate or other relevant documents of identity.  WHAT INFORMATION CAN BE DISCLOS  All Information described below  Benefits, Billing, and Claim Information  Primary Care Provider Changes	Identification Card Request Premium Payment  Name Spelling and other Personal Information												
If the person signing this authorization is not the attorney, birth certificate or other relevant document proof of identity.  WHAT INFORMATION CAN BE DISCLOS  All Information described below  Benefits, Billing, and Claim Information  Primary Care Provider Changes  Home Address Changes	Identification Card Request Premium Payment  Name Spelling and other Personal 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.

I understand that Community does not require that I waive my right to submit a claim to the Secretary of HHS in order to receive treatment, payment, enrollment in a health plan or determine eligibility of benefits.

### SIGNATURE AND AUTHORIZATION:

\*\*Date signed is the effective date of this 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.

I understand this authorization is completely voluntary. I can refuse to sign it, and I understand that treatment, coverage, enrollment, eligibility and/or other benefits cannot be conditioned upon my willingness to sign this authorization.

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SIGNATURE:	DATE: / / / / / / / / / / / / / / / / / / /
Signature of Individual or Individual	's Legally Authorized Representative
Printed name of legally Authorized Representatives (if applications)	able):
A minor individual signature is required for the release of cer release of information related to certain types of reproductive substance abuse, and mental health treatment:	
SIGNATURE:	_ DATE: / /

## Members: This completed form or letter of withdrawal can be submitted

E-mail: MemberServices@CommunityHealthChoice.org

Fax: 713.295.2293 – Fulfillment Department

Mail: Community Health Choice

Attention: Fulfillment Department 4888 Loop Central Dr. Suite 600

Houston, TX 77081

