Authorization to Use and Share Health Info

Notice to Member (Please Read All Pages):

- Filling out this form will allow Wellcare to (1) use your health info for a certain reason, and/or (2) share your health info with the person or group that you name on this form.
- You don't have to sign this form or give permission to use or share your health info. Your services and benefits with Wellcare will not change even if you don't sign this form.
- If you want to cancel this authorization form, ask us, in writing, to revoke it at the address on the next page. A revocation form can be sent to you by calling Member Services.
- Wellcare can't promise that the person or group that you name here to allow us to share your health info with won't share it with someone else.
- Keep a copy of all filled-out forms that you send to us. We can send you copies if you need them.
- Fill in all the info on this form. When you're done, mail it to the address on the next page.

MEMBER INFO:

Member Name (print): _____

Member Date of Birth: _____ Member ID Number: _____

I will allow Wellcare to use my health info for the purpose identified, or to share my health info with the person or group named below. The purpose of this form agreeing to share my health info is:

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

☐ to permit Wellcare to use or share my health info for _____.

PERSON OR GROUP TO GET INFO (add more Persons or Groups on page 2):

Name (person or group): _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

I AUTHORIZE WELLCARE TO USE OR SHARE MY HEALTH INFO. THIS INCLUDES:

☐ **All of my health info INCLUDING:** genetic info, services, or test results; HIV/AIDS data and records; mental health data and records (but not psychotherapy notes); prescribed drug/medication data and records; and drug and alcohol data and records.

☐ Please list any substance use disorder info that may be disclosed:

_____

(continued on next page)

☐ **I agree to share all of my health info EXCEPT (check all boxes that apply):**

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

Authorization End Date: _____ *(Date the authorization ends unless cancelled.* ***If this field is blank, the authorization expires one year from the date that you sign this form below):***

Member Signature: _____ **Date:**_____

(Member or Legal Representative Sign Here)

Relationship to Member: _____

If you are the Member's personal representative or agent, please send us copies of those forms (such as power of attorney or order of guardianship).

Mail to: *Wellcare, P.O. Box 10420, Van Nuys, CA 91410-0420 |* ***1-844-867-1156*** *(TTY:****711****)*
From October 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m. From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. A messaging system is used after hours, weekends, and on federal holidays.

MORE PERSONS OR GROUPS TO RECEIVE INFO:
NOTE: By filling out this form, you are agreeing for us to share any substance use disorder records with someone that is neither a third party payor nor a health care provider, facility, or program where you get services like a health insurance exchange or place that does research (hereafter, called "person or group"). ***Please note:***

- *You must give us the name of that person or group with whom or from which you receive services from a treating provider, OR,*
- *You can simply state that your substance use disorder records may be shared with your current and future treating providers at their place(s) of business.*

Name (person or group): _____
Address: _____
City: _____ *State:*_____ *Zip:*_____ *Phone:*_____

Name (person or group): _____
Address: _____
City: _____ *State:*_____ *Zip:*_____ *Phone:*_____

Name (person or group): _____
Address: _____
City: _____ *State:*_____ *Zip:*_____ *Phone:*_____

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City: _____ *State:*_____ *Zip:*_____ *Phone:*_____

Name (person or group): _____
Address: _____
City: _____ *State:*_____ *Zip:*_____ *Phone:*_____