Authorization to Use and Disclose Health Information

Attn: Enrollment Department - CCP
Wellcare Dual Liberty (HMO D-SNP)
PO Box 31378
Tampa FL 33631
Fax: 1-866-473-9124

Notice to Member:

- Completing this form will allow Wellcare Dual Liberty (HMO D-SNP) 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 Dual Liberty (HMO D-SNP) 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 Dual Liberty (HMO D-SNP) 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:

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  Tampa FL 33631
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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 Dual Liberty (HMO D-SNP) 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 Dual Liberty (HMO D-SNP) to help me with my benefits and services, **OR**

☐ to permit Wellcare Dual Liberty (HMO D-SNP) 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 Dual Liberty (HMO D-SNP) 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.

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

Attn: Enrollment Department - CCP Wellcare Dual Liberty (HMO D-SNP)

PO Box 31378, Tampa FL 33631

Fax: 1-866-473-9124

Additional individual person(s) or group(s) to receive information:

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: (______)______ - _________________