AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient's full name _____ Date of birth _____ Member or Subscriber ID # _____

Patient's street address _____ City/State/Zip _____

I understand and agree that:

- This authorization is voluntary;
- My health information may contain information created by others, including health care providers. It may include medical, pharmacy, dental, vision, mental health, substance use, HIV/AIDS, psychotherapy, reproductive, genetic, communicable disease and health care program information;
- I may not be denied treatment, payment for health care services, or enrollment or eligibility for health care benefits if I do not sign this form;
- The information I authorize to be disclosed may no longer be protected and could be re-disclosed by the recipient if the recipient is not subject to federal or state privacy laws; and
- This authorization will expire one year from the date I sign it. I may revoke this authorization at any time by notifying WellMed in writing; however, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed.

I authorize **WellMed and its affiliates** to use and disclose my individually identifiable health information between themselves.

I also authorize **my treating providers (past, present and future), to use and disclose my individually identifiable health information with WellMed and its affiliates.**

Treating provider(s) - check all that apply:*

☐ All providers with a confirmed treating relationship including WellMed contracted or affiliated providers

☐ These specific provider(s)_____

* I understand that consistent with 42 CFR Part 2, I have a right upon my request to be provided a list of entities to which my information has been disclosed pursuant to this general designation.

Type of Information to be Used, Disclosed and Shared:

☐ I authorize these entities to use and disclose all of my health information including medical, pharmacy, dental, vision, mental health, substance use, HIV/AIDS, psychotherapy, reproductive, genetic, communicable disease and health care program information. This information may include, for example, information relating to visits, admissions, treatment, claims, case management or care coordination; **OR**

Purpose of Disclosure:

☐ My health information is being disclosed to provide me with better treatment, payment facilitation, care coordination and/or case management.

Signature of individual _____ Date _____

Please note: If you are a guardian or court appointed representative, you must attach a copy of your legal authorization to represent the member.

Signature of individual's representative _____ Date _____

Personal Representative's:

Name _____ Phone number _____

Street address _____ City/State/Zip _____

(For general designations related to release of substance use disorder information only (e.g., all past, present and future treating providers)) I understand that I may request of list of entities to which my information has been disclosed.

PLEASE RETAIN THIS DOCUMENT IN THE PATIENT'S MEDICAL RECORD