WellMed®

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO WELLMED

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

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

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, behavioral health, 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,_____ hereby authorize _____ located at _____ to release the following patient information by mail, fax, electronically, or orally to:

WellMed at:_____ Attention: _____

Street address _____ City _____ State _____ Zip code _____

Phone:_____ Fax:_____

* If your request includes substance use disorder information to be shared with anyone other than health care providers or health plans, please provide a first and last name.

Health information to be disclosed upon the request of the person named above:
(CHECK EITHER A OR B)

☐ A. **DISCLOSE** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions)

☐ B. **DISCLOSE** my health record as above, BUT do not disclose the following (check as appropriate):

- ☐ Mental health records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Other (please specify):_____

CONTINUED ON NEXT PAGE

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Purpose of Disclosure:
(SELECT ONE OPTION)

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

☐ My health information is being disclosed for the following purpose(s) only (examples include claims management or payment, eligibility and benefits, disability management, etc.):

_____
(EXPLAIN PURPOSE)

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):
☐ An electronic record
☐ Hard copy

_____ _____
Signature of Individual Date

If the person signing the form is not the patient, provide full name, relationship to patient, phone number and address:

_____ _____ _____
Name Relationship Phone

_____ _____ _____ _____
Street address City State Zip code

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

PLEASE RETAIN THIS DOCUMENT IN THE PATIENT'S MEDICAL RECORD