



HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act of 1996 (45 CFR Parts 160 and 164))

The Notice of Privacy Practices of Carelon Advanced Primary Care, Inc. and its affiliated healthcare providers (together, "Carelon") provides information about how we may use or disclose protected health information ("PHI"). The notice contains a patient's rights section describing your rights under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). You represent by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. HIPAA expressly allows for the use of your PHI for treatment, payment, or healthcare operations, but you have the right to restrict how your PHI is used and disclosed for treatment, payment or healthcare operations.

In accordance with applicable state law and the HIPAA Privacy Rule, I hereby authorize:

A. The release of my entire medical record, to Carelon for treatment, payment, or healthcare operations related to my care.

B. Carelon's release of any PHI created by or in Carelon's possession, including my entire medical record, to the following person(s) or entity(ies):

- Any healthcare provider(s), including primary care physicians or physician specialists;
- Any healthcare entity(ies), including medical practices, hospitals, hospices or nursing homes;
- The following friends or family members involved in my care:

C. Additionally, Carelon may leave messages for me or my representative(s) that may contain PHI at the following number(s) if approved:

Part A: Your information			
Last name	First name	Middle initial	Date of birth
Street address	City	State	ZIP
Daytime telephone number (with area code)		Mobile telephone number (with area code)	
Part B: Person or company who will receive this information			
Name		Phone number	
☐ Voicemail Approved			

Part C: Information that can be released

I allow the following information to be used or released by or to Carelon on my behalf (check only one box):

- ☐ All my information. This can include health, a diagnosis (name of illness or condition), claims, doctors and other healthcare providers, and financial information (like billing and banking). This doesn't include sensitive information (see below) unless it is approved below.

OR

- ☐ Only limited information may be released (check all boxes below that apply to you):

- | | | |
|---|--|--|
| ☐ Appeal | ☐ Medical records | ☐ Pharmacy |
| ☐ Benefits and coverage | ☐ Referral | ☐ Pre-certification and pre-authorization (for treatment approvals) |
| ☐ Billing | ☐ Treatment | ☐ Diagnosis (name of illness or condition) and procedure (treatment): |
| ☐ Claims and payment | ☐ Dental | |
| ☐ Eligibility and enrollment | ☐ Vision | |
| ☐ Financial | ☐ Doctor and hospital | |

- ☐ I also approve the release of the following types of sensitive information by Carelon (check all boxes that apply to you):

- ☐ All sensitive information¹

OR

- ☐ Just information about topics checked below:

- | | |
|--|---|
| ☐ Abuse (sexual/physical/mental) | ☐ Sexually transmitted illness |
| ☐ HIV or AIDS | ☐ Mental health |
| ☐ Substance use disorder ^{1,2} | ☐ Reproductive health ³ (including abortion, maternity, etc.) |
| ☐ Genetic testing | |

1 Specify time period of records to be disclosed: _____

Description of records that may be disclosed: _____

2 Unless I specify otherwise on this form, I intend this disclosure to include all substance use disorder records maintained by Carelon about me. I understand that my substance use disorder records are protected under federal and state confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I also understand that I may revoke (or cancel) this approval at any time, or as described in Part E. I understand that I cannot cancel this approval when this form has already been used to disclose information.

3 Reproductive health includes, but is not limited to, both male and female infertility, maternity, pregnancy loss, miscarriage, family planning, birth control, both elective and spontaneous abortion, and any other related care or services.

Part D: Purpose of this approval

To give out the information as shown on this form.

Part E: Date your approval expires

If this document was not already withdrawn, this approval will end on the earliest of the following date:

☐ This approval will end: One year from signature date.

This authorization shall be in full force and effect for twelve (12) months from the date below or an earlier date specified.

Except to the extent that action has been taken based on this authorization, I have the right to revoke this authorization at any time by writing to Carelon.

I understand that signing this authorization is voluntary.

My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

Information disclosed under this authorization might be re-disclosed by the recipient, and any such re-disclosure may no longer be protected by federal or state law.

All items on this form have been completed and my questions about this form have been answered.

I have been provided a copy of this form.

Review and approval

I have read the contents of this form. I understand, agree, and allow the use and release of my information as stated above or as required by applicable law. I also understand that signing this form is of my own free will. I understand that I am not required to sign this form in order for me to receive treatment or payment, or for enrollment or eligibility of benefits. I have the right to withdraw this approval at any time by giving written notice of my withdrawal to the organization releasing my information. I understand that my withdrawing this approval will not affect any action taken before I do so. I also understand that information that's released may be given out by the person or group who receives it. If this happens, it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this form.

Signature or designated legal
representative/guardian signature

Date (MM/DD/YYYY)

X _____

Designated legal representative or guardian

Complete this section only if you have documentation supporting legal representation.

If this form is signed by someone other than the patient or parent, such as a personal representative, legal representative, or guardian, please submit the following:

- A copy of a healthcare, general, or durable power of attorney.

OR

- A court order or other documentation that shows custody or other legal documentation showing the authority of the legal representative to act on the patient's behalf. **Please complete the following:**

Legal representative (print full name)		Legal relationship to patient	
Legal representative street address	City	State	ZIP
Signature or designated legal representative/guardian signature		Date (MM/DD/YYYY)	
X _____		_____	

Please return the completed form to:

Carelon
22 Century Blvd., Suite 310
Nashville, TN 37214
Phone: 844-232-0500
Fax: 855-611-1917
Email: enrollment@carelon.com



Access it online at
carelon.com/mychart

Be sure to keep a copy of this form for your records.

For recipient of substance use disorder information

This information has been disclosed to you from records protected by Federal Confidentiality of Alcohol or Drug Abuse Patient Records rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any patient with a diagnosis of substance use disorder.

For internal use only:	Inquiry tracking number
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