Authorization for Sharing Health Information

[Please print]

AmeriHealth Caritas Next

A product of AmeriHealth Caritas Florida, Inc.

This form is used to share your protected health information (PHI) where required by federal and state privacy laws. Your authorization allows AmeriHealth Caritas Next to share your PHI with the person(s) or organization(s) that you choose. You can also choose to allow the person(s) or organization(s) to share your PHI with AmeriHealth Caritas Next. You can cancel this authorization at any time by submitting a request to AmeriHealth Caritas Next. Contact Member Services at **1-833-999-3567 (TTY 711)** for further instructions. We are available 8 a.m. – 8 p.m., Monday through Friday.

Part A. Member information: (individual whose PHI will be shared)

Member first name:		Middle initial:
Last name:	Member ID (see ID card):	
Member street address:		
City:	State:	ZIP code:
Member date of birth:	Daytime phone number (with area code):	

Part B. Recipient: (person or organization that will receive your PHI)

The following individual or organization has the right to receive my PHI:

Do you want the following individual or organization to also share your PHI with us? ☐ Yes ☐ No

First name:	Last name:	
Organization name (if applicable):		
Address:		
City:	State:	ZIP code:
Phone number (with area code):		
Relationship to member in Part A:		

Part C. Description of the PHI to be shared:

Tell us what types of PHI can be shared. You can check as many boxes as you want. At least one box must be selected.

☐ **Entire record.** All PHI related to the provision of and payment for my health care benefits and services. Federal law requires a separate authorization to share psychotherapy notes.

☐ **Special records. <u>Some laws require you to give specific permission to share certain PHI. Please check the boxes below for PHI that is OK to share</u>.** By checking these boxes, you give permission for all your records containing that type of PHI to be shared. If you only want to authorize sharing of a subset of records, such as records about only one diagnosis, fill out the "Only limited information" section below.

- ☐ Genetic information
- ☐ HIV/AIDS
- ☐ Substance or alcohol use
- ☐ Mental/behavioral health (including inpatient treatment)
- ☐ Sexually transmitted disease
- ☐ Abortion and family planning
- ☐ Communicable diseases
- ☐ Information you have asked us to treat confidentially

☐ **Only limited information.** In the box below, describe the PHI you want shared. Examples:

- The claim related to my service on [date].
- Appeal information related to my claim on [date].

Please describe the information you want shared:

Part D. Purpose of this authorization

This authorization is valid for sharing of PHI for the following purposes. (Please check one or both boxes).

☐ To help diagnose, treat, manage, and/or pay for my health needs.

OR

☐ For the following reason:

This authorization shall be invalid if used for any purpose other than the purpose(s) stated above.

Part E. Expiration date of this authorization

This authorization will expire. (Please check one box.)

☐ I want the authorization to expire one (1) year after my coverage with AmeriHealth Caritas Next ends. (See information below.)*

OR

☐ Upon the following date, event, or condition:*

* AmeriHealth Caritas Next must be notified of the event/condition to cancel this authorization. In North Carolina and New Jersey, this authorization automatically expires one year after the date it was signed, unless you choose an earlier date. In New Hampshire, the authorization automatically expires two years after the date it was signed, unless you choose an earlier date. In Louisiana, if you are requesting the sharing of genetic information, the authorization expires 60 days after the date it was signed, unless you choose an earlier date. In the District of Columbia, if you are requesting the sharing of mental health information, the authorization automatically expires one year after the date it was signed, unless you choose an earlier date.

Part F. Approval: (You OR your Personal Representative must sign and date this form in order for it to be complete.)

I understand that this authorization for sharing my PHI is voluntary and is not a condition of enrollment in AmeriHealth Caritas Next, eligibility for benefits, or payment of claims. I understand that I may cancel this authorization at any time by submitting a request to AmeriHealth Caritas Next, and that canceling this authorization will not affect any action taken pursuant to the authorization prior to my request to cancel. I also understand that if I cancel this authorization, I should separately notify the individual(s) or organization(s) listed in Part B above if I wish for those individual(s) or organization(s) to no longer share my PHI. I also understand that if the person or organization I authorize to receive my PHI described above is not subject to federal or state health information privacy laws, they may further share my PHI and it may no longer be protected by federal or state privacy laws. I also understand that I or my personal representative have a right to receive a copy of this form and to review my PHI that may be shared because of this authorization.

Member signature: By signing below, I authorize the sharing of my PHI as described above.	
Signature of member:	Date:

Personal Representative information: By signing below, I authorize the sharing of PHI of the member as described above. (A Personal Representative is a person who has the legal authority to act on behalf of an individual, such as a parent of a minor. A copy of a Power of Attorney or other legal document must be on file at AmeriHealth Caritas Next or submitted with this form.)	
Printed name of Personal Representative:	
Address of representative:	
Description of Personal Representative's authority:	
Signature of Personal Representative:	
Date:	Phone number:

Return the completed form to: Consent Processing Center, P.O. Box 7092, London, KY 40742-7092
Fax number: 1-833-214-2242 (toll-free)

Addendum to Authorization for Disclosure of Health Information

Verbal consent

We, the undersigned, attest that the member identified in Section A above is **physically unable** to sign this authorization. Verbal consent does not replace the need for documentation showing that another person is the member's personal representative and cannot replace this documentation simply because it is inconvenient for the member to sign.

Reason:

The signatures below indicate:

- The information on this form was communicated to the member.
- The member indicated their understanding of the information in this authorization.
- The member freely gave their consent.

Method of communication to member:

☐ Phone

☐ In person

☐ Other (specify):

Witness printed name:	Witness printed name:
Witness signature:	Witness signature:
Date: / /	Date: / /

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Notice of Nondiscrimination

AmeriHealth Caritas Next complies with applicable federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex, gender identity or expression, or sexual orientation. AmeriHealth Caritas Next does not exclude people or treat them differently because of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex, gender, gender identity or expression, or sexual orientation.

AmeriHealth Caritas Next provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

AmeriHealth Caritas Next provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Member Services at **1-833-999-3567 (TTY 711)**.

If you believe that AmeriHealth Caritas Next has failed to provide these services or discriminated in another way based on race, color, national origin, age, disability, sex, gender, gender identity or expression, you can file a grievance with:

AmeriHealth Caritas Next
Attention: Appeals and Grievances
P.O. Box 7379
London, KY 40742

Fax: **1-833-329-3567**

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

- Electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**
- By mail at:
  U.S. Department of Health and Human Services
  200 Independence Avenue SW, Room 509F, HHH Building
  Washington, DC 20201
- By phone at **1-800-368-1019 (TTY 1-800-537-7697)**

Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**.

English: You can get this material and other plan information in large print for free. To get materials in large print, call Member Services at **1-833-999-3567 (TTY 711)**.

If English is not your first language, we can help. Call **1-833-999-3567 (TTY 711)**. You can ask us for the information in this material in your language. We have access to interpreter services and can help answer your questions in your language.

Spanish: Puede obtener esta publicación y otra información del plan en letra grande de forma gratuita. Para recibir información en letra grande, llame a Servicios al Miembro al **1-833-999-3567 (TTY 711).**

Si el inglés no es su lengua materna, podemos ayudar. Llame al **1-833-999-3567 (TTY 711)**.
Puede solicitarnos la información que se encuentra en esta publicación en su idioma. Tenemos acceso a los servicios de interpretación y podemos ayudarlo a responder sus preguntas en su idioma.

Simplified Chinese: 您可以免费获取本资料内容及其他计划相关信息的大号字体版。如需获取以大号字体印刷的资料，请致电会员服务部 **1-833-999-3567 (TTY 711)**。

如果英语不是您的第一语言，我们可以提供帮助。请致电 **1-833-999-3567 (TTY 711)**。
您可以使用您的语言向我们索取本资料内容中的信息。我们可以提供口译服务，可以用您的语言解答您的问题。

Vietnamese: Quý vị có thể nhận được tài liệu này và các thông tin khác về chương trình ở dạng bản in chữ lớn miễn phí. Để nhận được tài liệu ở dạng bản in chữ lớn, vui lòng gọi tới Dịch Vụ Hội Viên theo số **1-833-999-3567 (TTY 711)**.

Nếu tiếng Anh không phải là tiếng mẹ đẻ của quý vị, chúng tôi có thể hỗ trợ. Vui lòng gọi **1-833-999-3567 (TTY 711)**. Quý vị có thể yêu cầu chúng tôi cung cấp thông tin trong tài liệu này bằng ngôn ngữ của quý vị. Chúng tôi có quyền tiếp cận các dịch vụ thông dịch và có thể giúp giải đáp thắc mắc bằng ngôn ngữ của quý vị.

Korean: 본 자료 및 기타 플랜 정보를 큰 활자체로 무료로 제공받을 수 있습니다. 큰 활자체의 자료를 제공받으려면 **1-833-999-3567 (TTY 711)** 으로 회원 서비스에 문의하십시오.

영어가 모국어가 아닌 경우, 저희가 도와드릴 수 있습니다. **1-833-999-3567 (TTY 711)** 으로 문의하십시오. 귀하의 언어로 된 본 자료의 정보를 요청하실 수 있습니다. 통역 서비스를 통해서 귀하의 질문에 대한 답변을 귀하의 언어로 제공하는 데 도움을 드릴 수 있습니다.

French: Vous pouvez obtenir gratuitement ce document et d'autres informations sur le plan en gros caractères. Pour ce faire, appelez l'équipe service aux membres au **1-833-999-3567 (TTY 711).**

Si l'anglais n'est pas votre langue maternelle, nous pouvons vous aider. Appelez au **1-833-999-3567 (TTY 711).** Vous pouvez nous demander les informations figurant dans ce document dans votre propre langue. Nous avons accès à des services d'interprétation et nous pouvons répondre à vos questions dans votre propre langue.

Arabic:

يمكنك الحصول على هذه المادة ومعلومات أخرى عن الخطة في مطبوعة كبيرة مجانًا. للحصول على مواد مطبوعة كبيرة اتصل بخدمات الأعضاء على **1-833-999-3567 (TTY 711)**.

إذا لم تكن اللغة الإنجليزية لغتك الأولى، فيمكننا مساعدتك. اتصل بالرقم **1-833-999-3567 (TTY 711)**. يمكنك أن تطلب منا المعلومات الموجودة في هذه المادة بلغتك.

لدينا إمكانية الوصول إلى خدمات مترجمين فوريين ويمكننا المساعدة في الإجابة عن أسئلتك بلغتك.

Hmong: Koj muaj peev xwm tau txais cov ntaub ntawv no thiab lwm cov lus qhia txog pawg kho mob sau ua ntawv luam loj pub dawb. Yog koj xav tau cov ntaub ntawv sau ua ntawv luam loj, hu rau Lub Thawj Fab Saib Xyuas Hauj Lwm Kev Pab Cuam Rau Tswv Cuab ntawm **1-833-999-3567 (TTY 711).**

Yog tias lus As Kiv tsis yog koj thawj hom lus, peb muaj peev xwm pab tau. Hu rau **1-833-999-3567 (TTY 711).** Koj muaj peev xwm nug peb tau txog rau cov lus qhia nyob rau hauv cov ntaub ntawv no hais ua koj hom lus. Peb muaj kev txuas cuag tau rau cov kev pab cuam fab kev txhais lus thiab muaj peev xwm pab teb tau koj cov lus nug hais ua koj hom lus.

Russian: Крупношрифтовые издания как данного печатного материала, так и другой информации о страховом плане вы можете получить бесплатно. Чтобы получить материалы, напечатанные крупным шрифтом, обратитесь в отдел обслуживания членов плана по телефону **1-833-999-3567 (TTY 711)**.

Если ваш родной язык не английский, мы можем помочь. Позвоните по телефону **1-833-999-3567 (TTY 711).** Вы можете попросить предоставить вам информацию, изложенную в данном печатном материале, на вашем языке. Мы имеем доступ к услугам переводчиков и можем ответить на ваши вопросы на вашем родном языке.

Tagalog: Maaari mong makuha ang babasahing na ito at iba pang impormasyon sa plano sa malaking print nang libre. Upang makakuha ng mga babasahin sa malaking print, tumawag sa Member Services (Mga Serbisyo para sa Miyembro) sa **1-833-999-3567 (TTY 711).**

Kung hindi mo unang wika ang Ingles, maaari kaming makatulong. Tumawag sa **1-833-999-3567 (TTY 711).** Maaari kang humingi ng impormasyon sa amin sa babasahing ito sa iyong wika. Mayroon kaming access sa mga serbisyo ng tagapagsalin at maaaring tumulong sa pagsagot sa iyong mga katanungan sa iyong wika.

Gujarati: તમે આ સાહિત્ય અને યોજનાની અન્ય માહિતી વિના મૂલ્ય મોટી પ્રિન્ટમાં મેળવી શકો છો. મોટી પ્રિન્ટમાં સાહિત્ય મેળવવા માટે, મેમ્બર સર્વિસીસને **1-833-999-3567 (TTY 711)** પર કૉલ કરો.

જો ઇંગ્લીશ તમારી પ્રથમ ભાષા ન હોય, તો અમે મદદ કરી શકીએ છીએ. **1-833-999-3567 (TTY 711)** પર કૉલ કરો. તમે આ સાહિત્યની માહિતી તમારી ભાષામાં મેળવવા અમને પૂછી શકો છો. અમારી પાસે દુભાષિયા સેવાઓ ઉપલબ્ધ છે અને તમારી ભાષામાં તમારા પ્રશ્નોના જવાબ આપવામાં અમે મદદ કરી શકીએ છીએ.

Mon-Khmer: អ្នកអាចទទួលបានឯកសារនេះនិងព័ត៌មានគម្រោងផ្សេងៗ ទៀតជាអក្សរពុម្ពធំដោយមិនគិតថ្លៃ។ ដើម្បីទទួលបានឯកសារជាអក្សរពុម្ពធំ សូមហៅទៅកាន់សេវាកម្មសមាជិកតាមរយៈលេខ **1-833-999-3567 (TTY 711)**។

ប្រសិនបើភាសាអង់គ្លេសមិនមែនជាភាសាទីមួយរបស់អ្នក យើងអាចជួយបាន។ ហៅទូរស័ព្ទទៅលេខ **1-833-999-3567 (TTY 711)**។ អ្នកអាចស្នើសុំ យើងខ្ញុំនូវព័ត៌មាននៅក្នុងឯកសារនេះជា ភាសារបស់អ្នក។ យើងមានសិទ្ធិទួល ប្រៃសេវាបកប្រែ និងអាចជួយអ្នកឆ្លើយសំណួររបស់អ្នកជាភាសារបស់អ្នក។

German: Dieses Material und andere Plan-Informationen sind kostenlos erhältlich. Um Materialien in großen Buchstaben zu bestellen, wenden Sie sich bitte unter **1-833-999-3567 (TTY 711)** an den Mitglieder-Service.

Falls Englisch nicht Ihre Muttersprache ist, helfen wir Ihnen gerne. Rufen Sie an: **1-833-999-3567 (TTY 711).**
Sie können die Informationen in diesem Material bei uns in Ihrer Sprache erhalten. Wir haben Zugang zu Dolmetscher-Diensten und können Ihre Fragen in Ihrer Sprache beantworten.

Hindi: आप को यह साहित्य और अन्य योजना जानकारी बड़े प्रिंट में मुफ्त प्राप्त हो सकती है। बड़े प्रिंट में यह साहित्य प्राप्त करने के लिए, **1-833-999-3567 (TTY 711)**। पर सदस्य सेवाओं को कॉल करें। यदि अंग्रजी आपकी मातृभाषा नहीं है, हम आपकी सहाय्यता कर सकते हैं। **1-833-999-3567 (TTY 711)**।
पर कॉल करें। आप अपनी भाषा में इस साहित्य की जानकारी मांग सकते हैं। हमारे पास दुभाषिया सेवाएं उपलब्ध हैं और आपकी भाषा में आपके सवालों के जवाब देने में सहाय्यता कर सकते हैं।

Laotian: ທ່ານສາມາດຮັບເອກະສານນີ້ ແລະຂໍ້ມູນແຜນການອື່ນໆ ໃນແບບພິມໃຫຍ່ໄດ້ຟຣີ. ເພື່ອຈະຮັບເອກະສານໃນຂະຫນາດໃຫຍ່, ກະລຸນາໂທຫາສູນບໍລິການສະມາຊິກທີ **1-833-999-3567 (TTY 711)**.
ຖ້າພາສາອັງກິດບໍ່ແມ່ນພາສາທຳອິດຂອງທ່ານ, ພວກເຮົາສາມາດຊ່ວຍໄດ້. ໂທຫາ **1-833-999-3567 (TTY 711)**.
ທ່ານສາມາດຂໍ ຂໍ້ມູນໃນເອກະສານນີ້ຈາກພວກເຮົາໃນ ພາສາຂອງທ່ານ ໄດ້. ພວກເຮົາສາມາດ ຂໍໃຫ້ມີບໍລິການ ນາຍພາສາແລະສາມາດ ຊ່ວຍຕອບຄຳ ຖາມຂອງທ່ານໃນ ພາສາຂອງທ່ານ.

Japanese: この資料とその他のプラン情報は拡大版で無料にて提供致します。拡大版を請求するには、メンバーサービス **1-833-999-3567 (TTY 711)** までお電話ください。英語が母国語でない方には、サポート致します。こちらにお電話下さい。**1-833-999-3567 (TTY 711))** 資料に関する情報をご自分の言語で請求することができます。また、通訳サービスによる質問対応が可能です。