Authorization to Use and Disclose Health Information

Notice to Member:

- Completing this form will allow Wellcare by Allwell 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 sign this form or give permission to use or share your health information. Your services and benefits with Wellcare will not change if you do not sign 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.
- Wellcare 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.
- Fill in all the information on this form. When finished, mail it to the address at the bottom of the first page.

MEMBER INFORMATION:

Member Name (print): _____

Member Date of Birth: _____ Member ID Number: _____

I give Wellcare 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:

□ to allow Wellcare to help me with my benefits and services, or

□ to permit Wellcare to use or share my health information for _____.

PERSON OR GROUP TO RECEIVE INFORMATION (add additional Persons or Groups on page 2):

Name (person or group): _____

Address: _____

City:_____ State: _____ Zip:_____ Phone: (___) ___ -_____

I AUTHORIZE Wellcare TO USE OR SHARE THE FOLLOWING HEALTH INFORMATION:

□ **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 all boxes 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: _____

Authorization End Date: / ____/____ *(date the authorization ends unless cancelled)*

Member Signature: ____Date: _____/____ / ____

(Member or Legal Representative Sign Here)

Relationship to Member:____

If you are the Member's personal representative, please send us copies of those forms (such as power of attorney or order of guardianship).

ADDITIONAL INDIVIDUAL PERSON(S) OR ENTITY(IES) 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:

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City: State: Zip: Phone: ( ) -