Authorization to Use and Disclose Health Information

Notice to Member:

- Completing this form will allow Ambetter from MHS (Ambetter) to (i) use your health information for a particular purpose, and/or 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 Ambetter will not change if you do not sign this form.
- Right to cancel (revoke): This authorization/consent form is subject to revocation at any time except to the extent that the Ambetter for other lawful holder of your health information that is permitted to share it has already acted in reliance on it. If you want to cancel this Authorization Form, fill out the Revocation Form on the last page and mail it to the address at the bottom of the page.
- Ambetter 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 Ambetter 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 Ambetter to help me with my benefits and services, or

☐ to permit Ambetter 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 Ambetter 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)

If you are signing for the Member, describe your relationship below. If you are the Member's personal representative, describe this below and send us copies of those forms (such as power of attorney or order of guardianship).

Mail to: Ambetter from MHS Attn: Privacy Officer, 550 N. Meridian St, Suite 101, Indianapolis, IN 46204
Phone: 1-877-687-1182 (TTY/TDD 1-800-743-3333)

ADDITIONAL INDIVIDUAL PERSON(S) OR ENTITY(IES) TO RECEIVE INFORMATION

NOTE: If you are consenting to disclose any substance use disorder records to an 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: ____________________

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: (_____) _____ - _________

Revocation of Authorization to Use and/or Disclose Health Information

I want to cancel, or revoke, the permission I gave to Ambetter to use my health information for a particular purpose or to share my health information with a person or group:

PERSON OR GROUP THAT RECEIVED THE INFORMATION:

Name (person or group): _____

Address: _____

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

Authorization Signed Date (if known): _____ /_____ /_____

MEMBER INFORMATION:

Member Name (print): _____

Member Date of Birth: _____ /_____ /_____ Member ID Number: _____

I understand that my health information (including, where applicable, my substance use disorder records) may have already been used or shared because of the permission I gave before. I also understand that this cancellation only applies to the permission I gave to use my health information for a particular purpose or to share my health information with the person or group. It does not cancel any other authorization forms I signed for health information to be used for another purpose or shared with another person or group.

Member Signature: _____ **Date:** _____ /_____ /_____

(Member or Legal Representative Sign Here)

If you are signing for the Member, describe your relationship below. If you are the Member's personal representative, describe this below and send us copies of those forms (such as power of attorney or order of guardianship).

_____

Ambetter will stop using or sharing your health information when we receive and process this form. Use the mailing address below. You can also call for help at the number below.

Ambetter from MHS
Attn: Privacy Officer
550 N. Meridian St, Suite 101
Indianapolis, IN 46204
Phone: 1-877-687-1182 (TTY/TDD 1-800-743-3333)

Mail to: Ambetter from MHS Attn: Privacy Officer, 550 N. Meridian St, Suite 101, Indianapolis, IN 46204
Phone: 1-877-687-1182 (TTY/TDD 1-800-743-3333)