AmeriHealth Caritas Florida

Authorization for Sharing Health Information

Please print clearly in blue or black ink.

This form is used to share your protected health information ("PHI") where your authorization is required by federal and state privacy laws. Your authorization allows AmeriHealth Caritas Florida 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 Florida. You can cancel this authorization at any time by contacting AmeriHealth Caritas Florida. Call Member Services at **1-855-355-9800 (TTY 1-855-358-5856)** for more information.

Part A. Member information (person 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):		
Member email address :			

Part B. Recipient (person or organization that will receive your PHI)			
The following person or organization has the right to receive my PHI:			
Do you want the following person 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:			
Recipient email address:			

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 checked. Note: Some sharing of PHI without your authorization is permitted by state and federal law.

☐ **Non-sensitive condition records.** All PHI related to my health and the provision of and payment for my health care benefits and services, **except for sensitive conditions as set forth below**.
Note: Federal law requires a separate authorization to share psychotherapy notes.

☐ **Sensitive condition records.** Some laws allow you to give specific permission to share sensitive PHI. Please check the boxes below for sensitive PHI that is OK to share. 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 on Page 2.

- ☐ Genetic information
- ☐ HIV/AIDS
- ☐ Substance or alcohol use
- ☐ Mental/behavioral health (including inpatient treatment)
- ☐ Sexually transmitted disease
- ☐ Abortion and family planning
- ☐ Communicable diseases

Part C. Description of the PHI to be shared (continued)

☐ **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 only one box.

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

OR

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

* AmeriHealth Caritas Florida 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 processed.

I understand that this authorization for sharing my PHI is voluntary and is not a condition of enrollment in AmeriHealth Caritas Florida, 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 Florida, 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 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 about the member listed above. (A personal representative is a person who has the legal authority to make health care decisions on the member's behalf. A copy of a power of attorney or other legal health care documents must be on file at AmeriHealth Caritas Florida 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 Sharing Health Information

Verbal consent

We, the undersigned, attest that the member listed in Part 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 member is unable to sign:

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 (explain):

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

AmeriHealth Caritas Florida

Discrimination is against the law

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

AmeriHealth Caritas Florida:

- Provides free (no-cost) 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).
- Provides free (no-cost) 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 AmeriHealth Caritas Florida at **1-855-355-9800 (TTY 1-855-358-5856)**. We are available 24 hours a day, seven days a week.

If you believe that AmeriHealth Caritas Florida has failed to provide these services or has discriminated against you in another way, you or your authorized representative (if we have your written authorization on file) can file a grievance with:

- Grievances and Appeals, P.O. Box 7368, London, KY 40742. Phone: **1-855-371-8078 (TTY 1-855-371-8079),** or Fax: **1-855-358-5847**.
- You can file a grievance by mail, fax, or phone. If you need help filing a grievance, AmeriHealth Caritas Florida Member Services is available to help you.

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**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019 (TTY 1-800-537-7697)

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

English: This information is available for free in other languages. Please contact our customer service number at **1-855-355-9800 (TTY 1-855-358-5856)**, 24 hours a day, seven days a week. If your primary language is not English, or to request auxiliary aids, assistance services are available to you, free of charge.

Spanish: Esta información está disponible en otros idiomas de forma gratuita. Póngase en contacto con nuestro número de servicios al cliente al **1-855-355-9800 (TTY 1-855-358-5856)**, las 24 horas del día, los siete días de la semana. Si su idioma principal no es el inglés, o necesita solicitar ayudas auxiliares, hay servicios de asistencia a su disposición de forma gratuita.

Haitian Creole: Enfòmasyon sa yo disponib gratis nan lòt lang. Tanpri kontakte ekip sèvis kliyan nou an nan **1-855-355-9800 (TTY 1-855-358-5856)**, 24 è sou 24, sèt jou sou sèt. Si anglè pa lang manman w oswa si w ta renmen mande yon èd konplemantè, ou ka resevwa sèvis ki gratis pou ede w.

Vietnamese: Thông tin này có sẵn miễn phí ở các ngôn ngữ khác. Vui lòng liên lạc bộ phận dịch vụ khách hàng của chúng tôi theo số **1-855-355-9800 (TTY 1-855-358-5856)**, 24 giờ một ngày, bảy ngày trong tuần. Nếu ngôn ngữ chính của quý vị không phải là tiếng Anh, hoặc để yêu cầu các thiết bị trợ giúp bổ sung, thì quý vị có thể sử dụng miễn phí các dịch vụ hỗ trợ.

AmeriHealth Caritas™