Authorization to Disclose Protected Health Information

Use this form to authorize CarePartners of Connecticut to use or disclose your protected health information. **All fields are required. Incomplete or incorrect forms will be returned.**

Member Name:	**Member ID:** ☐☐☐☐☐☐☐☐☐☐☐
Member Address:	
Member City/State/Zip:	
Member Date of Birth:	**Member Phone #:**

I hereby authorize CarePartners of Connecticut to disclose the protected health information listed below to the following person/entity:

Name:	
Relationship To Member:	**Address:**
	City/State/Zip

Please specify what information you would like to be disclosed to the individual listed above :

☐ All* my Protected Health Information **(except Sensitive Information [see below])*

☐ *Only* my claim(s) information

☐ *Only* my benefits information

☐ Other *(please describe)*:

<u>Sensitive Information</u>: If CarePartners of Connecticut has any of the following types of information, you must check off the box next to the category before we can disclose the information*:*

☐ Information related to my diagnosis, treatment, and/or referral for substance use disorder, including information received through claims, care management and/or utilization review.

☐ Information related to my diagnosis and/or treatment for HIV/AIDS

☐ Results of genetic testing

Describe the purpose for the disclosure (be specific, e.g., "To assist with claims payment" or you may write, "At my request"):

This authorization will remain in effect:

☐ For as long as necessary to complete the purposes of this Authorization.

☐ From the date of this Authorization until the following date: ___________________________

☐ Until the following event occurs:

Please Note:

- You have a right to revoke this authorization in writing at any time and to send your written revocation to CarePartners of Connecticut at the address listed below. Your revocation will not apply to information that CarePartners of Connecticut has already disclosed in reliance on this Authorization.
- Information disclosed by CarePartners of Connecticut in accordance with this request may be re-disclosed by the recipient and may no longer be protected by the HIPAA Privacy Regulations.
- CarePartners of Connecticut will not condition payment, enrollment in the health plan, or eligibility for benefits on you providing this authorization.
- While this form allows for the release of PHI to the person or party indicated, it does not allow that person or party to access the member's PHI online through the member portal.

Signature:

I have read and understand the above information. I represent that the signature below is my own and that I am legally authorized to sign this document.

Member, Parent, or Personal Representative* Signature

Print Name **Date**

Relationship, if signed by other than Member: ______________________

* If not already provided, please attach legal documentation verifying personal representation. We will require verification of the authority of a Personal Representative before this request will be considered complete.

Please Return this Completed Form and Supporting Documentation:

Fax this form

(and documentation, if applicable)

to: **1-617-972-9405**

Or mail to:

CarePartners of Connecticut
Member Services
P.O. Box 9181
Watertown, MA 02471-9181

If you have any questions about this Authorization Form, please contact the Member Services department at: 1-888-341-1507 (TTY: 711). Representatives are available Monday - Friday 8:00 a.m. - 8:00 p.m. (Representatives are available 7 days a week, 8:00 a.m. - 8:00 p.m. from October 1 – March 31). After hours and on holidays, please leave a message and a representative will return your call the next business day.

Note to recipients of substance use disorder information related to this authorization *(if applicable)***:**

This information has been disclosed to you from records protected by federal confidentiality rules (*42 CFR part 2*). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed 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 (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65.