AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

ConnectiCare

By completing this form, you are authorizing ConnectiCare Inc. and its affiliates, employees and agents (collectively "ConnectiCare") to use or disclose your protected health information, as defined by law, for the purpose stated below.

FORM INSTRUCTIONS

The instructions below explain each numbered section of the authorization form. Please refer to them as you complete the form. If you have additional questions, please contact Member Services at the number on the back of your ID card.

SECTIONS

1 **Member Information:** Fill in your information carefully, legibly and completely.

2 **Recipient of Information:** Tell us who you want to receive your protected health information.

3 **Purpose of the Authorization:** Check the box that applies and add any other information that we may need to know in order to disclose your information.

4 **Information to Be Disclosed:** Tell us what information you are authorizing your plan to disclose by checking the appropriate box. If you want only specific information disclosed, tell us what type of information you would like us to disclose. We will not disclose certain types of sensitive information (such as behavioral health and HIV/AIDS information) unless specific authorizations are given or otherwise permitted or requested by law. Check the boxes to release any sensitive information.

5 **Term of Authorization:** How long should your plan continue to release this information? Please check the first box to indicate a specific day, month and year upon which this authorization should expire (end). Or, check the second box and describe the event upon which this authorization should expire (end). Please note that if you do not provide an expiration (end) date or event, your authorization will stay in effect until you cancel it in writing or the date your coverage ends with ConnectiCare.

6 **Conditions of Authorization:** Please read this section all the way through as it provides information related to this request.

7 **Signature Required:** Sign and date on the line provided to complete this authorization. If a legal representative (someone with legal authority to act on the member's behalf) is signing this authorization, check the appropriate box explaining your relationship to the member and provide documentation of legal authority to act on the member's behalf.

Please fill in member data carefully, legibly and completely, otherwise the form will not be considered valid. Use the instruction sheet to guide you. After completing the form, fax it to 860-674-2232 or mail it to the following address:

ConnectiCare, Attention: Member Services, PO Box 4050, Farmington, CT 06034-4050.

1 Member Information: (please print)

Member ID#: _____

Member Name: _____

Telephone Number: _____

2 Recipient of Information: (please print)

Name: _____

Address: _____

Telephone Number: _____

Relationship: _____

3 Purpose of the Authorization:

☐ At my request.

OR

☐ For the following purposes: _____

4 Information to Be Disclosed:

I authorize my plan to disclose my protected health information as follows:

☐ All my information. This can include clinical, claims, billing, benefit or coverage information. This does not include sensitive information (see below) unless it is approved below.

OR

☐ Specific information only. Please list: _____

Sensitive Information:

I also approve the release of the following types of sensitive information checked below:

☐ Alcohol abuse/substance abuse ☐ Sexually transmitted disease

☐ Mental or Behavioral health (excluding psychotherapy notes) ☐ HIV/AIDS

☐ Genetic testing

5 Term of Authorization:

This authorization is valid from the date of my/my representative's signature below and shall expire (end) as of the following:

☐ Authorization should expire (end) on _____
Month/day/year

OR

☐ Upon the following event: _____

NOTE: I understand that if I fail to specify an end date or event, the authorization will remain in effect until I request in writing to cancel it or until the date my coverage ends with ConnectiCare, whichever is earlier.

6 Conditions of Authorization:

I understand that:

- The information disclosed under this authorization may be further disclosed by the recipient and no longer protected by state and federal privacy laws.
- I have the right to revoke (cancel) this authorization at any time, and that the revocation (cancellation) must be in writing and sent to the address noted on this form.
- Any revocation (cancellation) will become effective as soon as my plan receives my written notice. I understand that the revocation will not affect any action taken by my plan in reliance on the authorization prior to receiving my written notice of revocation.
- This authorization is voluntary and I may refuse to sign this authorization. My plan will not condition my enrollment or eligibility for health benefits on my provision of the authorization. My plan may not condition payment of a claim for specified health benefits on my provision of this authorization.
- If I am authorizing the release of alcohol or drug abuse treatment information, I acknowledge that the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my further written authorization, unless permitted to do so under federal or state law.
- I have a right to have a copy of this authorization.

7 Signature Required:

I have read and I understand the terms of this authorization. I have also had a chance to ask questions about how my protected health information will be used and disclosed. By signing this authorization, I am affirming that to the best of my knowledge all information provided on this form is complete, accurate and consistent with my directions. I hereby provide my agreement to the terms authorizing the use and disclosure of my protected health information in the manner described in this form.

Signature of Member _____ Date _____

If applicable, Legal Representative (including the parent/guardian of a minor child) sign below: By signing this form, I represent that I am the legal representative of the Member identified above and am legally authorized to act on the Member's behalf with respect to this authorization form.

Signature of Legal Representative _____ Date _____

☐ Parent ☐ Legal Guardian/Conservator* ☐ Power of Attorney* ☐ Other* _____

*Provide written documentation supporting your legal authority to act on the member's behalf.

Questions?

Please call us at 1-800-224-2273 (TTY 1-800-842-9710)

from 8 a.m. - 8 p.m. seven days a week.

ConnectiCare, Inc. is an HMO/HMO-POS plan with a Medicare contract. Enrollment in ConnectiCare depends on contract renewal. ConnectiCare, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-224-2273 (TTY: 1-800-842-9710). ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-224-2273 (TTY: 1-800-842-9710).