CareAmerica
Life Insurance Company

Authorization for CareAmerica Life Insurance Company to Disclose Personal & Health Information to a Third Party

This authorization is voluntary. CareAmerica places no conditions on our payment activities in connection with your claims, your enrollment in our health plan or your eligibility for benefits because you have given this authorization. You May Refuse To Sign This Authorization

Section A: This authorization relates to the personal and health information of the following person:

Member Information

Name: _____ Date of birth: _____

Telephone: _____ Policy number: _____

Relationship to Policyholder: _____

Section B: This authorization is for the release of the following types of personal and health information (check all that apply):

- ❑ Dues payment and billing information
- ❑ Claims
- ❑ Medical care and treatment
- ❑ Other (describe) _____

*If this authorization is for mental health/substance abuse or HIV information, a separate completed authorization form from those above will be necessary for the release of information (1) protected by the LPS Act or (2) containing HIV results. Further, the LPS Act often requires that both the patient's treating physician and the patient sign the authorization form before information may be released.

- ❑ *Mental health/substance abuse care and treatment (if selected, no other boxes may be checked)
- ❑ *Mental health – protected by the Lanterman-Petris-Short Act (LPS) on involuntary treatment of mental illness (if selected, no other boxes may be checked)
- ❑ *HIV care, HIV results, and treatment (if selected, no other boxes may be checked)

Section C: Persons or entities authorized to receive and use member information

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Section D: Purpose and Limitations of This Authorization. By Signing this Form you Authorize the Use and Disclosure of your Personal and Health Information by a Third Party for the Following Purposes:

CareAmerica will obtain specific written authorization for disclosure of any personal and health information, beyond those necessary to provide treatment, facilitate payment, perform the operations of the health plan, or as permitted by law. CareAmerica recognizes your right to specifically approve or to deny the release of information. CareAmerica will only disclose that information which is reasonably necessary to achieve the purpose of the request for release.

Please also include any limitations you would like to place on the use of this information:

_____

_____

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_____

Section E: Expiration and Revocation

This authorization for the release of your personal and health information may be revoked or withdrawn at any time and a revocation or withdrawal will apply to all information not previously released pursuant to this authorization. No other personal or health information may be disclosed without your authorization, unless permitted by law. Request for revocation must be made in writing, unless CareAmerica has taken action in reliance on this authorization or it was obtained as a condition of obtaining healthcare plan coverage. This authorization for the release of your personal and health information will expire in one year or on the date you specify, whichever is later.

Note: If this authorization is for the release of the personal and health information of a minor the expiration date cannot exceed the 18th birthday of the minor.

Expiration: This authorization will expire (on _____/_____/_____)

Section F: Signature – You may refuse to sign this authorization.

I,_____ , have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization that "CareAmerica" may use and/or disclose to the persons and/or organizations named in this form the personal and health information described in this form for the purposes stated in this form. I understand that, if the persons or organizations I authorize to receive and/or use the personal and health information described in this form are not health plans, covered health care providers or healthcare clearinghouses subject to federal health information privacy laws, they may further disclose the personal and health information and it may no longer be protected by federal health information privacy laws.

Signature: _____ Date: _____

Print Name: _____

Person or Entity Authorizing Disclosure of Information: If you are signing on behalf of the member, please indicate your relationship to the member and provide copies of verification of your legal right to authorize the disclosure of the member's personal and health information.

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- ❑ Parent or guardian of minor patient (to the extent minor could not have consented to the care)
- ❑ Court appointed guardian, legal conservator, legal representative or an individual with Power of Attorney to disclose the member's personal and health information
- ❑ Durable Power of Attorney for Health Care
- ❑ Beneficiary or personal representative of deceased patient
- ❑ Spouse or person financially responsible (where information is solely for purpose of processing an application for enrollment)

Treating Physician (signature may be necessary if related to mental health or HIV care)

Physician Signature: _____ Date: _____

Print Name: _____

You can request a copy of this authorization after you sign it. A copy of this authorization shall be considered as effective and valid as the original. Additionally, you may inspect or copy the personal and health information to be used or disclosed.