Authorization to Disclose Health Information

Notice to Member:

- Completing this form will allow **Ambetter Health** to share your health information with the person or group that you identify below.
- You do not have to sign this form or give permission to share your health information. Your services and benefits with **Ambetter Health** will not change if you do not sign this form.
- Right to cancel (revoke): When you want to cancel this Authorization Form, fill out the Revocation Form on the next page and mail it to us at the address at the bottom of the page.
- **Ambetter Health** cannot promise that the person or group you want 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. **Ambetter Helath** 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 page.

Member Information:
Member Name (print): _____

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

I give Ambetter Health permission to share my health information with the person or group (recipient) named below. The purpose of the authorization is to help me with Ambetter Health benefits and services.

Recipient Information:

Name (person or group): _____

Address: _____

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

Ambetter Health can share this Health Information: (check all boxes that apply)

- ☐ All of my PHI; **OR**
- ☐ All of my PHI **EXCEPT**:
  - ☐ Prescription drug/medication information
  - ☐ Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) information
  - ☐ Treatment for alcohol and/or substance abuse information
  - ☐ Behavioral health services or psychiatric care information
  - ☐ 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 court order of guardianship).

_____

Mail To: Ambetter Health Attn: Privacy Officer, 429 N. Pennsylvania Street, Suite 109, Indianapolis, IN 46204
Phone: 1-877-687-1182 (TTY/TDD 1-800-743-3333)

Revocation of Authorization to Disclose Health Information

(Keep this form and use it when you want to cancel your Authorization)

I want to cancel, or revoke, the permission I gave to **Ambetter Health** to share my health information with this person or group:

Recipient 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 may have already been shared because of the permission I gave before. I also understand that this cancellation only applies to the permission I gave to share my health information with this person or group. It does not cancel any other authorization forms I signed for health information to be 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 Health will stop sharing your health information when we get this form. Use the mailing address below. You can also call for help at the number below.

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Phone: 1-877-687-1182 (TTY/TDD 1-800-743-3333)