AmeriHealth Caritas
VIP Care

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 VIP Care (HMO-SNP) 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 VIP Care. You can cancel this authorization at any time by contacting AmeriHealth Caritas VIP Care. Call Member Services at **1-833-535-3767 (TTY 711)**. Call Monday – Friday, 8 a.m. to 8 p.m., from April 1 – September 30, or seven days a week, 8 a.m. to 8 p.m., from October 1 – March 31 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 VIP Care ends. (See information below.)*

OR

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

* AmeriHealth Caritas VIP Care 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 VIP Care, 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 VIP Care, 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 VIP Care 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: