WellCare
Beyond Healthcare. A Better You.

Authorization to Release Protected Health Information (PHI) and Records

Purpose of Authorization

Please sign this form. It will confirm that WellCare may discuss or disclose PHI to:

- a person you have picked to act as your authorized representative;
- a provider; or
- any person you choose and assign.

Member Information

Print Member Name: ____________________________ DOB (mm/dd/yyyy): ____________

Address: ____

Telephone Number: _________________ Member ID Number: _________________________

Medicare Number: ____________________ Medicaid Number: _____________________

Authorized Uses

By signing this form, I agree that WellCare may share my PHI with the person named on the form.

Check all items that WellCare can discuss with or release to the person you have named to act for you.

- ☐ Psychotherapy notes. (**Please note**: If you check this box, you may not check other boxes. You must fill out an *Authorization to Release Health Information and Records* to get other types of records.)
- ☐ Entire health record (includes all options below)
- ☐ Appeals and grievances
- ☐ Claims history
- ☐ Diagnoses and/or treatment for alcohol and/or drug abuse
- ☐ Diagnoses and/or treatment of AIDS, AIDS Related Complex (ARC), HIV, or other communicable diseases
- ☐ Other:____

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Representative Information

Print Name of Representative: ____________________ DOB (mm/dd/yyyy): ______________

Address: ____

Telephone Number: ____

Relationship to Member: ____

The Authorized Representative you appoint will only be able to discuss your PHI and will not be able to make any changes on your behalf. If this person is a foster parent, we will need you to show proof. This could be state or agency proof (i.e., on state letterhead).

Acknowledgment

I understand:

- My authorization is voluntary.
- I authorize the health plan to discuss and disclose my PHI to an authorized representative appointed in this form.
- I may revoke this authorization at any time by providing my written revocation to the health plan. I may call the toll-free number on my membership identification card and request a revocation form to help me submit my written request.
- Submitting a revocation form will not revoke any other authorizations to release information that I have provided to the health plan. Revocation of this authorization will not affect any action that the health plan has taken, or any PHI that the plan has already released.
- The health plan may not condition the provision or treatment or payment for my care on my signing this document.
- This authorization form will expire two years following the termination of my enrollment.
- My authorized representative is not a healthcare provider or another business subject to federal or applicable state privacy laws. Those privacy laws may no longer protect my PHI and my authorized representative may further disclose my information without my authorization.
- The information authorized for release may include records that may indicate the presence of a communicable or non-communicable disease.
- The information authorized for release may include protected health information and/or records related to mental health. Release of mental health records or psychotherapy notes may require consent of the treating provider or a court order.

- The information authorized for release may include drug/alcohol abuse treatment records. This category of medical information/records is protected by federal confidentiality rules 42 CFR Part 2. The federal rules prohibit anyone receiving this information or record from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or is otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. As a result, by signing below, I specifically authorize such records included in my health information to be released.
- I have the right to get a copy of this form after it has been signed.

____
Signature of Member or Authorized Representative

____
Print name of Member or Authorized Representative

____
Date

Please return this form or your request to revoke authorization to:

WellCare
Attn: Enrollment Department – CCP
PO Box 31378
Tampa Fl 33631

Fax: 1-866-473-9124