ROI Form: Authorization for Use or Disclosure of Health Information

NOTE: This form does not authorize health care decision-making authority

1. Member/Patient information

Name: ______ *Last Name, First Name, Middle Initial*	**DOB:**	**CCA ID:**
Address: ______ *Street Address, City/State, Zip Code*	**Phone:**	**Email Address:**

2. Permission to release/disclose Member/Patient health information

I authorize CCA/CCA Primary Care to ☐ Disclose Member/Patient health information to **or** ☐ Obtain from

Person/Organization Name: ______________________________ Phone: ____-____-____ Email: ____________________________

Street Address: ______________________________ City: ____________________ State: _________ Zip Code: _______________

Description: ☐**Full or** ☐**Partial Record** ☐For this time frame: ___/___/___ **To**: ___/___/_____ or ☐ Indefinite

Purpose: ☐At the request of the Member/Patient/other individual ☐Other: ______

In the form of: ☐ Oral/Written and/or ☐Electronic/Paper Copies by: ☐Fax ☐Email ☐Delivery or Pick-up

3. Sensitive Information: You must initial each box below in order for us to release this sensitive information

Abortion		Behavioral Health		HIV	
AIDS/ARC		Genetic Testing		Physical Abuse	
Alcohol & Substance Use		Domestic Violence		Sexually Transmitted Infection	
Reproductive Health					

4. Expiration and Cancellation

Unless otherwise revoked, this AUTHORIZATION is valid for the Member's enrollment term with CCA or as specified:

☐On this date: ______/______/__________ OR Event: ______

5. SIGN BELOW: The signature below is my own and I am legally authorized to sign this document

Member/Patient or Personal Representative* Signature: ________________________________ **Date:** _____/_____/___

Print your name, phone number, and email below. Check (✓) the box that shows your legal authority under law to sign this form on the Member/Patient's behalf.* ***Please return this completed form with supporting documentation.*

Print Personal Representative Full Name: ____________________________ **Phone:** ___-___-_____ **Email:** __________________

☐ **Attorney** ☐ **Guardian/Conservator** ☐ **Health Care Agent** ☐ **HIPAA Agent/Representative**

☐**Representative of Estate/Executor** ☐ **Power of Attorney** ☐ **Other Advocate**

I understand that the health information disclosed pursuant to this Authorization may be re-disclosed by the recipient and may no longer be protected by law. I have the right to revoke this Authorization in writing at any time by sending written revocation to the address below. I understand that my treatment, payment, enrollment in the health plan or eligibility for benefits does not depend on my signing this Authorization. The entity that seeks this Authorization must provide me with a copy of this signed form.

Please mail, fax, or email as indicated below. For questions call Member Services at: 866-610-2273

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