Authorization to Release Personal Health Information

Once signed, this form authorizes CCA Health Michigan, Inc. (CCA Health), and its affiliates (referred to collectively as "CCA Health " in this form) to disclose personal and health information held by CCA Health. Your consent to release information is voluntary and you may refuse to sign this authorization. CCA Health will not withhold treatment, payment, enrollment or eligibility for benefits based on whether or not you sign this authorization.

When completed, please return this form to:

CCA Health

Attention: Member Services
PO BOX 25677
TAMPA, FL 33622

The form must be signed and dated. Incomplete forms will be returned to you unprocessed.

1. I hereby authorize the disclosure of personal and health information relating to:

   Name: _____

   Date of birth: _____

   Health plan ID number: _____

2. Information to be disclosed (If left blank, CCA Health, assumes that any of the following types of information may be disclosed if otherwise consistent with this authorization.):

   - ☐ Enrollment or eligibility Information (e.g., effective date, type of coverage)
   - ☐ Medical management information (e.g., referrals, services received, health status info)
   - ☐ Claims and billing information (e.g., status of claims for health services, premium due)
   - ☐ Customer service records (e.g., network or assigned primary care doctor, etc.)
   - ☐ Other (specify): _____

Unless you initial below, CCA Health, will not disclose information relating to the conditions described below:

(initials) I understand that the disclosed information may be related to alcohol and drug abuse treatment, psychological or psychiatric treatment, human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) or AIDS-related complex (ARC), communicable diseases or infections, venereal diseases, tuberculosis or hepatitis. Any alcohol and substance use information disclosed to your authorized representative is protected by federal confidentiality rules (42 CFR part 2). They prevent your authorized representative from making any further disclosure of this information unless you give written permission or as otherwise allowed by 42 CFR part 2.

_____
(initials) psychotherapy notes

3. Disclosure is to be made to: _____

_____ **(initials)**: The requested information will be provided over the phone or sent by mail. If you want to authorize CCA Health, to fax the disclosure to the above recipient, please provide the fax number here:

_____

When number 3 is completed above please supply the following information:

Name:_____

Relationship to member:_____

Phone number:_____

Address:_____

4. This disclosure is made at your request or the request of your representative. Unless, otherwise revoked, this authorization expires one year from the date it's signed unless another expiration date or expiration event is written here. We cannot accept "indefinitely." You must enter a specific date or event.

_____

5. I understand that I may revoke this authorization at any time, but that I must do so in writing to the health plan. I understand that information that has already been disclosed by the health plan cannot be revoked. My notification must be addressed to:

   CCA Health | Attention: Member Services, PO BOX 25677, TAMPA, FL 33622

6. I understand that, if the health plan requested this authorization, I have the right to receive a copy of this authorization after I sign it.

7. I understand that the persons to whom information is disclosed under this authorization may possibly re-disclose the information to others without my knowledge or consent and, therefore, the privacy of my personal and health information may no longer be protected by law.

Signature: _____ Date: _____

Printed name: _____

If signed by a person other than the member, please indicate the relationship and provide documentation that proves the authority of the person to act for the member.

- ☐ Legal guardian
- ☐ Parent of minor
- ☐ Personal representative of a deceased or living person
- ☐ Power of attorney Patient
- ☐ advocate designee

To better serve you, please answer the following optional questions.

1. What language do you speak most of the time? _____
2. Do you need or want an interpreter to communicate with a doctor or health care provider?

   ☐ Yes ☐ No

CCA Health, does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in the administration of the plan, including enrollment and benefit determinations.