CareConnect
Healthier Insurance

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

SECTION A: Member Information (Please Print)

Member's Name: _____

Address: _____

Member Identification Number: _____ Date of Birth: _____(MM/DD/Year)

Group or Account # on ID card: _____

Phone number where we can reach you to process your request (required) : (_____) _____-_____

SECTION B: Information Regarding This Authorization

I, or my authorized representative, request that health information regarding my care and treatment be used and disclose as set forth on this form. In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG TREATMENT, MENTAL HEALTH TREATMENT,** except psychotherapy notes, **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION** and **GENETIC INFORMATION** accordance with applicable law and only if I initial the appropriate place in Section F. In the event the health information described below includes any of these types of information, and I initial the appropriate place in Section F, I specifically authorize release of such information to the person(s) indicated in Section D.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient, and this re-disclosure may no longer be protected by federal or state law. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization, unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the entity listed in Section C below. I understand that I may revoke this authorization except to the extent that action has already been taken in reliance on this authorization prior to my withdrawal.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

SECTION C: Person or Company Who Will Disclose This Information

Name of entity to release this information:

CareConnect Insurance Company, Inc. ("CareConnect")

SECTION D: Person or Company Who Will Receive This Information

Name, relationship (if applicable), address, telephone and fax numbers of person(s) or entity/category of person to whom this information will be disclosed:

SECTION E: Purpose of This Disclosure

Reason(s) for releasing information under this authorization:

CareConnect
Healthier Insurance

SECTION F: Information That Can Be Released

I authorize the following information to be used or disclosed by CareConnect on my behalf:

☐ **All my information.** This may include health information, claims information, enrollment information or financial information, with the exception of sensitive information.

OR

☐ **Only limited information (check all that apply):**

☐ **Claims Information** ☐ **Enrollment Information** ☐ **Other Information:**_____

☐ **Limited to the following conditions:** _____

☐ **Limited to the following dates: Start Date**_____ **End Date**_____**(MM/DD/YEAR)**

I also authorize the use or release of the following types of sensitive information by CareConnect *(please select all that apply):*

☐ **Mental Health Related Information** ☐ **HIV/AIDS-Related Information**

☐ **Alcohol/Drug Treatment Information** ☐ **Genetic Information**

☐ **Limited to the following conditions:** _____

☐ **Limited to the following dates: Start Date**_____ **End Date**_____**(MM/DD/YEAR)**

SECTION G. Expiration of Authorization

This approval will end on the earlier of:

☐ Date: _____ (MM/DD/YEAR)

OR

☐ Upon termination of enrollment in CareConnect

SECTION H: Review and Approval

I have reviewed the contents of this form. I understand, agree and allow CareConnect to use and release my information as described above.

Member Signature	Date
X	

Legal Guardian/Representative Information

Name:_____ _____
(Print) (Signature)

Relationship to Individual: _____ Date: _____

Please note: *If you are a personal representative for the member, you must attach copies of your authorization as required by state law to represent the member – for example, power of attorney, health care proxy or guardianship papers.*

Please Return this Completed Form via Fax to (516) 706-3829 or Mail to:

CareConnect Insurance Company, Inc.
Attention: Privacy Officer
2200 Northern Boulevard, Suite 104
East Hills, NY 11548

PLEASE MAKE A COPY OF THIS FORM FOR YOUR RECORDS