HIPAA Authorization Form

HIPAA Privacy rules may require your written authorization for certain disclosures of your protected health information. If you want Essence Healthcare to disclose your information to another party, please complete, and sign this authorization form. You must complete all of the sections of this authorization in order for it to take effect.

If you have any other questions or need additional assistance, including free language translation services, please call toll free 1-866-597-9560, from 8 a.m. to 8 p.m., seven days a week. You may reach a messaging service on weekends from April 1 through September 30 and holidays. TTY users can call 711 toll free. You may also visit our website anytime at www.everythingessence.com.

A. **Member Name**____ **ID#** ______________________

Member authorizes and requests Essence Healthcare to release Member's information to the following individual(s):

B. **Recipient Name** ____

Recipient Address ____

Recipient Name ____

Recipient Address ____

Recipient Name ____

Recipient Address ____

The individuals listed above are permitted to notify the Plan if their contact information is changed.

C. **This authorization applies to (check all that apply)**.

- ❑ All member information (e.g. all medical, dental, pharmacy, vision, care management information)
- ❑ One service only:
  Date of service____________________ Doctor/Supplier ___________________________
- ❑ All services from specific doctor or supplier: Doctor/Supplier ___________________________

D. **State how long you wish this authorization to be in effect (check one):**

- ❑ Until specific date or event: ____________________________
- ❑ Upon termination of enrollment in the health plan

E. **Member Signature**

This authorization is voluntary and refusal to sign this authorization will have no effect on your enrollment, eligibility for benefits or the amount Essence Healthcare pays for the health services you receive. You may revoke this authorization by sending a written revocation to the address at the end of this form. I understand that if the person or entity to whom information is disclosed is not a health care provider or health plan subject to federal privacy regulation, the personal information may be redisclosed without the protection of the federal privacy regulations.

____ ______________________

Signature of Member **Date**

(If signed by someone other than Member, see Section F)

F. **Legal Representative**
If this authorization is signed by a legal representative or someone other than the Essence Healthcare member identified in Section A above, complete the following.

By signing this form, I represent that I am the legal representative of the Essence Healthcare member identified in Section A and will provide Essence Healthcare with written proof (e.g. Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the member's behalf with respect to this authorization form.

Name of Legal Representative: ____

Signature: ____

Date: ____

Relationship to Member: ____

Return this form to: **Essence Healthcare**
P.O. Box 5907
Troy, MI 48007