

HIPAA Privacy rules may require your written authorization for certain disclosures of your protected health information. If you want Essence Healthcare (HMO) 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.

A. **Member Name** _____ **ID#** _____

Authorizes and requests Essence Healthcare to release information to:

B. **Recipient Name** _____

Recipient Address _____

C. **This authorization applies to:**

- One service only:
Date of service _____ Doctor/Supplier _____
- All services (all dates and all providers)
- All services from specific doctor or supplier: Doctor/Supplier _____
- Medicare eligibility information
- Information on other health coverage: _____
- Deductible information for (year): _____
- Copy of Explanation of Benefits for:
Date of service _____ Doctor/Supplier _____

D. **State how long you wish this authorization to be in effect:**

- One time release
- Until specific date or event: _____
- Ongoing release* until otherwise revoked. A revocation will not apply to information already released.

**State privacy laws required that this authorization will expire 24 months after the date signed.*

If you have any other questions or need additional assistance, including free language translation services, please call us at 314-209-2700 or toll free 1-866-597-9560, from 8 a.m. to 8 p.m., seven days a week. TTY users can call 711 toll free. You may reach a messaging service on weekends from April 1 through September 30 and holidays. Please leave a message, and your call will be returned the next business day. You may also visit our website anytime at www.everythingessence.com.

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

Essence Healthcare is an HMO plan with a Medicare contract. Enrollment in Essence Healthcare depends on contract renewal.

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(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**