carolina complete health

Authorization to Use and Disclose Health Information

Notice to Member

- Completing this form will allow Carolina Complete Health to (i) use your health information for aparticular purpose, and/or (ii) share your health information with the individual or entity that you identifyon this form.
- You do not have to give permission to use or share your health information. Your services and benefits withCarolina Complete Health will not change if you do not submit this form.
- If you want to cancel this authorization form, send us a written request to revoke it at the address on thebottom of this page. A revocation form can be provided to you by calling Member Services at the phonenumber on the back of your member ID card.
- Carolina Complete Health cannot promise that the person or group you allow us to share your healthinformation with will not share it with someone else.
- Keep a copy of all completed forms that you send to us. We can send you copies if you need them.
- If you need help, contact Member Services at the phone number on the back of your member ID card.
- Fill in all the information on this form. When finished, mail the form and any supporting documentation to

Carolina Complete Health
ATTN: Member Services
1701 North Graham St., Suite 101
Charlotte, NC 28206
Fax: 833-537-2330
Email: NCMEMBER@CarolinaCompleteHealth.com

Aviso al (la) afiliado(a):

- Al llenar este formulario, usted autoriza a Carolina Complete Health a (i) que use su información desalud para un fin en particular, y/o (ii) que la dé a conocer a la persona o entidad que usted identifiqueen este formulario.
- Usted no tiene que firmar este formulario ni dar permiso a usar o dar a conocer su información de salud. Sus servicios y beneficios de Carolina Complete Health no cambiarán si usted no firma este formulario.
- Si desea cancelar este formulario de autorización, envíenos por escrito una solicitud para revocarlo a la dirección que aparece al final de esta página. Servicios para los afiliados puede proporcionarle unformulario de revocación si les llama al número telefónico que se encuentra en la parte trasera de sutarjeta de identificación de afiliación.
- Carolina Complete Health no puede prometer que la persona o el grupo al que nos permita dar a conocer su información de salud no la dará a conocer a alguien más.
- Conserve una copia de todos los formularios llenos que nos envíe. Si las necesita, podemos enviarle copias.
- Si necesita ayuda, comuníquese con Servicios para los afiliados al número telefónico que aparece en la parte trasera de su tarjeta de identificación de afiliación.
- Llene toda la información en este formulario. Al terminar, envíe el formulario y todos los documentos de apoyo a

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AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

PLEASE READ THE INSTRUCTIONS CAREFULLY AND COMPLETE THE FORM BELOW. INCOMPLETE FORMS CANNOT BE ACCEPTED.

1 MEMBER INFORMATION:

Member Name (*print*): _____

Member Date of Birth: _____ Member ID Number: _____

2 I GIVE Carolina Complete Health PERMISSION TO USE MY HEALTH INFORMATION FOR THE PURPOSE IDENTIFIED OR TO SHARE MY HEALTH INFORMATION WITH THE PERSON OR GROUP NAMED BELOW. THE PURPOSE OF THE AUTHORIZATION IS (*check one option below*):

☐ to allow Carolina Complete Health to help me with my benefits and services, **OR**

☐ to permit Carolina Complete Health to use or share my health information for _____

3 PERSON OR GROUP TO RECEIVE INFORMATION (*add more Persons or Groups on next page*):

Name (person or group): _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: (_____) _____ - _____

4 I AUTHORIZE Carolina Complete Health **TO USE OR SHARE THE FOLLOWING HEALTH INFORMATION** (*NOTE: Select the first statement to release ALL health information or select the below statement to release only SOME health information.* ***Both CANNOT be selected.***)

☐ **All of my health information INCLUDING:**

Genetic information, services or test results; HIV/AIDS data and records; mental health data and records (but not psychotherapy notes); prescription drug/medication data and records; and drug and alcohol data and records (please specify any substance use disorder information that may be disclosed);

OR

☐ **All of my health information EXCEPT** (*check only the boxes below that apply*):

- ☐ Genetic information, services or tests
- ☐ AIDS or HIV data and records
- ☐ Drug and alcohol data and records
- ☐ Mental health data and records (but not psychotherapy notes)
- ☐ Prescription drug/medication data and records
- ☐ Other: _____

5 THIS AUTHORIZATION ENDS ON THIS DATE/EVENT: _____

Date this authorization ends unless cancelled. If this field is blank, the authorization expires one year from the date of the signature below.

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6 MEMBER OR LEGAL REPRESENTATIVE SIGNATURE: _____ **DATE:** _____

IF LEGAL REPRESENTATIVE - Relationship to Member: _____

If you are the Member's legal or personal representative, ***you must send us copies of relevant forms****, such as power of attorney or order of guardianship.*

MAIL COMPLETED AUTHORIZATION FORM AND ANY SUPPORTING DOCUMENTATION TO Carolina Complete Health,

ATTN: Member Services

1701 North Graham St., Suite 101, Charlotte, NC 28206 Fax: 833-537-2330 | Email: NCMEMBER@CarolinaCompleteHealth.com

ADDITIONAL INDIVIDUAL PERSON(S) OR GROUP(S) TO RECEIVE INFORMATION:

NOTE: If you are consenting to disclose any substance use disorder records to a recipient that is neither a third party payor nor a health care provider, facility, or program where you receive services from a treating provider, such as a health insurance exchange or a research institution (hereafter, "recipient entity"), you must specify the name of an individual with whom or the entity at which you receive services from a treating provider at that recipient entity, or simply state that your substance use disorder records may be disclosed to your current and future treating providers at that recipient entity.

Name (individual or entity): ______________________________

Address: ______________________________

City: ______________ State: ____________ Zip: ________ Phone: (_____) _____ - ________

Name (individual or entity): ______________________________

Address: ______________________________

City: ______________ State: ____________ Zip: ________ Phone: (_____) _____ - ________

Name (individual or entity): ______________________________

Address: ______________________________

City: ______________ State: ____________ Zip: ________ Phone: (_____) _____ - ________

Name (individual or entity): ______________________________

Address: ______________________________

City: ______________ State: ____________ Zip: ________ Phone: (_____) _____ - ________

Name (individual or entity): ______________________________

Address: ______________________________

City: ______________ State: ____________ Zip: ________ Phone: (_____) _____ - ________

Name (individual or entity): ______________________________

Address: ______________________________

City: ______________ State: ____________ Zip: ________ Phone: (_____) _____ - ________

Name (individual or entity): ______________________________

Address: ______________________________

City: ______________ State: ____________ Zip: ________ Phone: (_____) _____ - ________

Name (individual or entity): ______________________________

Address: ______________________________

City: ______________ State: ____________ Zip: ________ Phone: (_____) _____ - ________