Authorization to Use and Disclose Health Information

NOTICE TO MEMBER:

- Completing this form will allow Wellcare Prime by Absolute Total Care (Medicare-Medicaid Plan) to (i) use your health information for a particular purpose, and/or (ii) share your health information with the individual or entity that you identify on this form.
- You do not have to sign this form or give permission to use or share your health information. Your services and benefits with Wellcare Prime will not change if you do not sign this form.
- If you want to cancel this authorization form, send us a written request to revoke it at the address on the bottom of this page. A revocation form can be provided to you by calling member services.
- Wellcare Prime cannot promise that the person or group you allow us to share your health information 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.
- Fill in all the information on this form. When finished, mail it to the address at the bottom of the first page.

MEMBER INFORMATION:

Member Name (print): _____

Member Date of Birth: _____ Member ID Number: _____

I give Wellcare Prime 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:

□ to allow Wellcare Prime to help me with my benefits and services, or

□ to permit Wellcare Prime to use or share my health information for _____.

PERSON OR GROUP TO RECEIVE INFORMATION (add additional Persons or Groups on page 2):

Name (person or group): _____

Address: _____

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

I AUTHORIZE Wellcare Prime TO USE OR SHARE THE FOLLOWING HEALTH INFORMATION:

□ **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 all boxes 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: _____

Mail to: Wellcare Prime, 100 Center Point Circle,
Columbia SC, 29210
1-855-735-4398 (TTY: 711)

Authorization End Date: ___ /___ / __ *(date the authorization ends unless cancelled)*

Member Signature: ____**Date:** ____ / ___ / ____
(Member or Legal Representative Sign Here)

Relationship to Member:____
If you are the Member's personal representative, please send us copies of those forms (such as power of attorney or order of guardianship).

ADDITIONAL INDIVIDUAL PERSON(S) OR ENTITY(IES) 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):
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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: ( ) -*

Absolute Total Care (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and South Carolina Healthy Connections Medicaid to provide benefits of both programs to enrollees.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-735-4398 (TTY: 711) de 8 a.m. a 8 p.m., de lunes a viernes. Luego del horario de atención, los fines de semana y los días feriados federales, es posible que se le pida que deje un mensaje. Le devolveremos la llamada el próximo día hábil. La llamada es gratuita.

Notice of Non-Discrimination. Absolute Total Care (Medicare-Medicaid Plan) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Absolute Total Care does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Absolute Total Care:
→ Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).
→ Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Absolute Total Care's Member Services at 1-855-735-4398 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on federal holidays, you may be asked to leave a message. Your call will be returned within the next business day.

If you believe that Absolute Total Care has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance by calling the number above and telling them you need help filing a grievance; Absolute Total Care's Member Services is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, (TDD: 1-800-537-7697).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Services
ATTENTION: If you do not speak English, language assistance services are available to you, free of charge. Call 1-855-735-4398 (TTY: 711).
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-735-4398 (TTY: 711).
ملحوظة: إذا كنت لا تجيد التحدث باللغة الإنجليزية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-735-4398 (رقم هاتف الصم والبكم: 711).
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-735-4398 (TTY: 711).
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-735-4398 (TTY: 711).
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-735-4398 (TTY: 711).
ATENÇÃO: Se você fala português do Brasil, os serviços de assistência em sua lingua estão disponíveis para você de forma gratuita. Chame 1-855-735-4398 (TTY: 711).
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請 電 1-855-735-4398（TTY：711）。
RUAHSAKNAK: Mirang ttong hmang nan um silen, Mirang ttong thawn pehpar aw in a lak in bawm nak a um. Himi ah in contact thei asi: 1-855-735-4398 (TTY: 711).
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-855-735-4398 (TTY: 711) पर कॉल करें।
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-735-4398 (TTY: 711) 번으로 전화해 주십시오.
THEIHTERNAK: Mirang holh a thiammi na si ahcun, holh lei kongkau bawmchanh khawhnak a lak in nangmah caah a um. Hika hin au hna 1-855-735-4398 (TTY-711).
ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-735-4398 (ATS : 711).
ဟ်သူဉ်ဟ်သးဘဉ်တက္ၢ်–ဖဲနမ္ၢ်တကတိၤအဲးကလံးအကျိာ်ဘဉ်နူဉ်,ကျိာ်အတၢ်ဆီဉ်ထွဲမၤစၢၤအတၢ်ဖံးတၢ်မၤတဖဉ်အိဉ်ဝဲဒဉ်လၢနကျိာ်လၢတလိဉ် ဟ့ဉ်အမှၤဘဉ်နူဉ်လီၤ.ကိးဘဉ် 1-855-735-4398 (TTY: 711) တက္ၢ်.
ማሳሰቢያ፦ አማርኛ የሚናገሩ ከሆነ የቋንቋ እገዛ አገልግሎቶች ያለ ምንም ክፍያ ለእርስዎ ሊሰጡ ይችላሉ። ወደ 1-855-735-4398 (TTY: 711) ይደውሉ።
သတိပြုရန်။ သင် မြန်မာစကားပြောပါက အခမဲ့ ဘာသာပြန် ဝန်ဆောင်မှုကို ရရှိနိုင်သည်။ 1-855-735-4398 (TTY: 711) ကိုခေါ်ပါ။