CareFirst Community Health Plan Maryland

Member Consent & Authorization To Release of Protected Health Information (PHI)

Consent and Notice of Privacy Practices

This consent form allows CareFirst BlueCross BlueShield Community Health Plan Maryland (CareFirst CHPMD) and any of its subsidiaries, and affiliates and their respective employees to use and disclose information about me protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to carry out treatment, payment, or health care operations while I am enrolled in the plan.

CareFirst CHPMD has provided me with a *Notice of Privacy Practices*, which completely describes uses and disclosures of my protected health information. CareFirst CHPMD provided this notice prior to my signing this form in accordance with my right to review its practices before signing consent.

I understand that the terms of the *Notice of Privacy Practices* may change and that I may obtain revised notices by either writing to CareFirst CHPMD, Attention: Compliance Department, PO Box 915, Owings Mills, Maryland 21117. Or by calling CareFirst CHPMD's Member Services Department at 410-779-9932 or toll free at 1-844-386-6762, 8 AM to 8 PM, Eastern Time, 7 days a week from October 1 through March 31 and 8 AM to 8 PM, Monday through Friday from April 1 through September 30. TTY users please call 711.

Right to Request Plan's Use and Disclosure of Protected Health Information

☐ I understand that I have the right to request – now and in the future – how protected health information is used or disclosed to carry out treatment, payment, and health care operations. I understand that while CareFirst CHPMD is not required to agree to my requested restrictions, if it does agree, it is bound by that agreement. I understand that CareFirst CHPMD may refuse me services if I refuse to sign this consent.

Member Consent & Authorization To Release of Protected Health Information (PHI)

☐ I hereby authorize CareFirst CHPMD and any of its subsidiaries, and affiliates and their respective employees to release my PHI to those individuals specifically designated in Section 2 of this *Member Consent & Authorization to Release Protected Health Information Form* based on the level of access I have selected below:

Levels of Access *(please check the appropriate level of access granted)*

☐ **Appointment of Representative For Limited Actions**

When you grant this level of access, you are stating that the individual is authorized to

1. Act as your representative in requesting health care services and/or payment of claims from the health plan.

2. Make any changes to the demographics in your membership record, including but not limited to address changes, telephone number changes, email address changes, and request for a replacement ID card.
3. Make any request; present or elicit evidence; obtain appeals and grievance information; and to receive any notice in connection with your appeal or grievance, wholly in your stead. You understand that personal medical information related to your appeal or grievance may be disclosed to the representative(s) indicated in Section 2 of this *Member Consent & Authorization to Release Protected Health Information Form.*

☐ **Appointment of Representative For Information Only**

When you grant this level of access, you are stating that the individual is authorized to receive information from the health plan about your benefits, premiums, services, providers, enrollment, and health plan operations, but they do not have the authority to act on your behalf in requesting services, filing appeals or grievances, or changing any of your demographic information.

☐ **Durable Power of Attorney/Legal Guardian/Other Legal Representative**

This level of access is utilized when you have written legal documentation that authorizes the individual to act on your behalf in private affairs, business, healthcare decisions, contracts, finance, or some other legal matter. You must attach a copy of the legal documentation and/or court order with this form to grant this level of access.

If the remaining portion of this form is not completed, as applicable, CareFirst CHPMD will be unable to process your request. Incomplete forms will be returned. PLEASE PRINT YOUR RESPONSES.

(1) Member Information

Last Name	*First Name*	*MI*
Member ID Number	*Birth Date*	*Daytime Telephone Number*
Street Address	*City, State and ZIP Code*	
I am enrolled in: ☐ CareFirst BlueCross BlueShield ☐ Community Health Plan Maryland		

(2) Based on the "Level of Access" indicated above, I appoint the following individuals to receive PHI pertaining to the Member identified in Section 1 above.

A. Individual authorized to receive PHI	*Daytime Telephone Number*
Street Address	*City, State and ZIP Code*
Relationship to Member:	

B. Individual authorized to receive PHI	*Daytime Telephone Number*
Street Address	*City, State and ZIP Code*
Relationship to Member	

(3) Your signature below means that you understand and agree to the following:

- The PHI made available to the individuals(s) identified in Section 2 above may include diagnosis and treatment information.
- Information disclosed as permitted by this authorization may be redisclosed by the recipient and may no longer be protected by federal or state privacy regulations.
- You may receive a copy of this signed form if you ask for it by writing to the address listed on the first page.

(4) Signature of Member or Member's Legal Representative:

Minors must sign this form below if (*check applicable box*):	All others must sign this form below as (check applicable box):
1. ☐ the minor is married or emancipated or, 2. ☐ the information being authorized for release pertains to drug or alcohol treatment or, 3. ☐ the information authorized for release pertains to one of the following conditions and applicable state law permits the minor to receive treatment for these conditions without consent of parent/legal guardian: a. mental health b. sexually transmitted diseases (including HIV/AIDS) c. reproductive health (including contraception, prenatal care and abortion) d. general medical and dental health.	4. ☐ the Member or Member's legal representative or, 5. ☐ the parent/legal guardian of unemancipated minor, unless minor has signed at left, box 2 has been checked, and state law requires signature of parent/legal guardian for drug or alcohol treatment. 6. ☐ the parent/legal guardian of unemancipated minor, unless minor has signed at left and box 3 at left has been checked.

Signature	Date
Print Name	
If the person signing this Authorization is not the Member, describe relationship to the Member (i.e. Parent/Legal Guardian, Legal Representative):	

Revoke This Consent and Authorization

I understand that I have the right to revoke this consent and authorization at any time provided that I do so in writing, but that CareFirst CHPMD and any other entity working directly with CareFirst CHPMD for the purposes of carrying out treatment, payment, or health care operations on my behalf may still use information to complete any actions that it began prior to my revoking consent and which rely on my protected health information. I understand that this consent and authorization shall remain valid and in force until I revoke it or my enrollment in CareFirst CHPMD terminates, whichever occurs first.

Requests to Revoke this Consent and Authorization should be sent to:

CareFirst BlueCross BlueShield Community Health Plan Maryland
Attention: Compliance Department
PO Box 915
Owings Mills, MD 21117