Interoperability Authorization Form

CareFirst Community Health Plan Maryland

THIRD PARTY INFORMATION
I have asked CareFirst BlueCross BlueShield Community Health Plan Maryland (CareFirst CHPMD) to share detailed information about my health history to a third party such as a hospital, lab or other provider ("App"):

YOU MUST COMPLETE THE FOLLOWING		
Enrollee Last Name	First Name	MI
Date of Birth (mm/dd/yyyy) / /	Medicaid Number	
Address		
Address		
City	State	Zip
Phone ( )		

By my signature below, after completing this form, I allow CareFirst CHPMD to share the following information:

Please note: I will only be able to get the information I select below.

Check all that apply:

- ○ Enrollment Information
- ○ Benefit Information
- ○ Claim and encounter data – related to health care provider services
- ○ Clinical data collected as part of case management, care coordination or other services
- ○ Procedure Codes
- ○ Substance use disorder treatment information
- ○ Mental health treatment information
- ○ HIV/AIDS status information
- ○ Diagnosis codes
- ○ Explanation of benefit information

This authorization or permission is voluntary. It will remain in effect for one (1) year from the date sent to CareFirst CHPMD. I understand that CareFirst CHPMD will not require payment for health care, enrollment in a health plan or eligibility for benefits on this permission. Please note that this authorization or permission will not be effective until the form is submitted.

This authorization may be revoked or cancelled at any time by submitting a request in writing or online (URL electronic HIPAA revocation (cancellation) template):

Please submit all written requests to the address below:

CareFirst CHPMD, Inc. Privacy Office
PO BOX 14858
Lexington, KY 40512
Fax: 410-505-6692
Email: privacy.office@carefirst.com

When you cancel this authorization or permission, the cancellation will be effective for future uses and sharing of protected health information but will not affect any sharing CareFirst CHPMD already made based on this authorization.

DISCLAIMER

By my signature below, I direct CareFirst CHPMD to disclose my personal information to the App that I have selected. By doing so, I acknowledge that:

- The App is **NOT** subject to HIPAA or other laws specifically designed to safeguard my privacy; CareFirst CHPMD is **NOT** responsible for anything that happens to my personal information after it is disclosed to the App; some of the information to be disclosed was **NOT** created by CareFirst CHPMD and CareFirst CHPMD is **NOT** required to and does **NOT** verify the accuracy of the information before disclosing it to the App; CareFirst CHPMD is **NOT** responsible for the accuracy of the information or whether the information is current; and CareFirst CHPMD is required to comply with my request to disclose my personal information to the App, even if the App fails to appropriately secure my personal information.
- I understand that the released information may no longer be protected by federal privacy laws and may be redisclosed by the individual or organization that receives it.

TO THE MAXIMUM EXTENT PERMITTED BY LAW, CAREFIRST CHPMD WILL NOT BE LIABLE FOR ANY INCIDENTAL, INDIRECT, SPECIAL, CONSEQUENTIAL OR PUNITIVE DAMAGES, WHETHER INCURRED DIRECTLY OR INDIRECTLY, RESULTING FROM (A) DISCLOSURE OF YOUR PERSONAL INFORMATION IN ACCORDANCE WITH THIS REQUEST; OR (B) ANY UNAUTHORIZED ACCESS TO, OR USE OR RE-DISCLOSURE OF YOUR PERSONAL INFORMATION THAT TAKES PLACE AS A RESULT OF CAREFIRST CHPMD'S DISCLOSURE. THESE LIMITATIONS APPLY TO ANY THEORY OF LIABILITY, WHETHER BASED ON CONTRACT, TORT (INCLUDING NEGLIGENCE), STATUTE, OR OTHERWISE, AND WHETHER [CAREFIRST CHPMD] HAS BEEN INFORMED OF THE POSSIBILITY OF ANY SUCH DAMAGE.

I have read and considered the contents of this disclaimer. I understand that, by signing below, I am confirming my desire for CareFirst CHPMD to disclose my personal information to the App I have selected.

Signature	Date

ACKNOWLEDGMENT

By signing below you acknowledge that the App named above is not subject to federal health information privacy laws such as HIPAA and any information the App receives will no longer be subject to such laws.

If you are the personal representative of a member, we may need to collect more information from you before processing your request.

Please indicate the basis of your status as a personal representative:

○ Parent or guardian of a minor ○ Active health care power of attorney ○ Court ordered guardianship of person

Please provide the following Personal Representative information:

Name		
Email Address	Phone Number	
Address		
Address		
City	State	Zip

ACKNOWLEDGMENT (CONTINUED)

If I change my Personal Representative or I need to change the types of information I previously authorized my Personal Representative to access, I understand that I will be required to complete a new HIPAA Authorization Form. I read and considered the contents of this authorization or permission. I understand that, by signing below, I am confirming my authorization for the disclosures of information, as described above.	
Enrollee Name	Date
Signature	Date