BayCarePlus™
Medicare Advantage

HIPAA Authorization Form

HIPAA Privacy rules may require your written authorization for certain disclosures of your protected health information. If you want **BayCare**Plus 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#** _____

*Member authorizes and requests **BayCare**Plus to release Member's information to the following individual(s):*

B. **Recipient Name** _____

Recipient Address _____

Recipient Name _____

Recipient Address _____

Recipient Name _____

Recipient Address _____

The individuals listed above are permitted to notify the Plan if their contact information is changed.

C. **This authorization applies to (check all that apply)**:

- ❑ All services (all dates and all providers) and member information
- ❑ 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 (check one):**

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

If you have any other questions or need additional assistance, including free language translation services, please call us at (866) 509-5396, from 8am to 8pm, 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 Member.BayCarePlus.org.

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 **BayCare**Plus 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**

(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 **BayCare**Plus member identified in Section A above, complete the following.

By signing this form, I represent that I am the legal representative of the **BayCare**Plus member identified in Section A and will provide **BayCare**Plus 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: **BayCare Health Plans**
P.O. Box 3710
Troy, MI; 48007