WELLMED®

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION WITHIN WELLMED

Patient's full name ______ Date of birth ______ Member or subscriber ID # ______

Patient's street address ______ City ______ State ______ Zip code ______

I understand and agree that:

- This authorization is voluntary.
- My health information may contain information created by others, including health care providers. It may include medical, pharmacy, dental, vision, behavioral health, mental health, substance use, HIV/AIDS, psychotherapy, reproductive, genetic, communicable disease and health care program information.
- I may not be denied treatment, payment for health care services, or enrollment or eligibility for health care benefits if I do not sign this form.
- The information I authorize to be disclosed may no longer be protected and could be re-disclosed by the recipient if the recipient is not subject to federal or state privacy laws.
- This authorization will expire one year from the date I sign it. I may revoke this authorization at any time by notifying WellMed in writing. However, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed.

I authorize **WellMed and its affiliates** to access, use and disclose my individually identifiable health information between themselves. I also authorize **my treating providers (past, present and future), to access, use and disclose my individually identifiable health information with WellMed and its affiliates.**

Treating provider(s) - check all that apply:*

☐ All providers with a confirmed treating relationship including WellMed contracted or affiliated providers

☐ These specific provider(s)

______

______

______

* I understand that consistent with 42 CFR Part 2, I have a right upon my request to be provided a list of entities to which my information has been disclosed pursuant to this general designation.

Health information to be used, disclosed and shared:

(SELECT ONE OPTION)

☐ I authorize these entities to access, use and disclose all of my health information including medical, pharmacy, dental, vision, mental health, substance use, HIV/AIDS, psychotherapy, reproductive, genetic, communicable disease and health care program information. This information may include, for example information relating to visits, admissions, treatment, claims, case management or care coordination; or

☐ I authorize only the disclosure of the following information:

______

(TYPE OF INFORMATION)

CONTINUED ON NEXT PAGE

Purpose of Disclosure:
(SELECT ONE OPTION)

☐ My health information is being disclosed to provide me with better treatment, payment facilitation, care coordination and/or case management; **or**
☐ My health information is being disclosed for the following purpose(s) only (examples include claims management or payment, eligibility and benefts, disability management, etc.):

____
(EXPLAIN PURPOSE)

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):
☐ An electronic record
☐ Hard copy

______________________________ ____________
Signature of Individual Date

If the person signing the form is not the patient, provide full name, relationship to patient, phone number and address:

______________________________ ____________ ____________
Name Relationship Phone

______________________________ ____________ ______ ______
Street address City State Zip code

Please Note: If you are a guardian or court appointed representative, you must attach a copy of your legal authorization to represent the patient.

(For general designations related to release of substance use disorder information only (e.g., all past, present and future treating providers)) I understand that I may request of list of entities to which my information has been disclosed.

PLEASE RETAIN THIS DOCUMENT IN THE PATIENT'S MEDICAL RECORD

The company does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities. We provide free services to help you communicate with us such as letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call 888-781-9355. ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 888-781-9355. 請注意：如果您說 中文 (Chinese)，我們免費為您提供語言協助服務。請致電：888-781-9355 。

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION TO HEALTH INFORMATION EXCHANGES (HIES) AND INTEROPERABILITY EXCHANGES

Patient's full name	Date of birth	Member or subscriber ID #

Patient's street address	City	State	Zip code

I understand and agree that:

- This authorization is voluntary and I may not be denied treatment, payment for health care services or enrollment or eligibility for health care benefits if I do not sign this form;
- Greater Houston Healthconnect, Carequality, Commonwell* and any future HIEs to which WellMed connects and their current and future participants may access, use, and disclose my Protected Health Information (PHI) electronically through the exchanges for the purposes of treatment, payment, and health care operations;
- These entities may connect to other HIEs in Texas and across the country and I authorize these entities to access, use, and disclose my information with those exchanges for the same treatment, payment, and health care operation purposes;
- My PHI, including notes, test results, lab reports, x-rays, medication lists, or any other relevant electronic PHI may be shared through these exchanges;
- My PHI may be subject to re-disclosure by the recipient entities and if those recipients are not health care providers or health plans, the information may no longer be protected by the federal privacy regulations; and
- This authorization remains in effect unless and until I revoke it. I may revoke this authorization at any time by giving written notice to WellMed. I understand that revoking this authorization will not have an effect on any actions taken prior to the date my revocation is received and processed.

Signature of Individual	Date

If the person signing the form is not the patient, provide full name, relationship to patient, phone number and address:

Name	Relationship	Phone

Street address	City	State	Zip code

Please Note: If you are a guardian or court appointed representative, you must attach a copy of your legal authorization to represent the patient.

PLEASE RETAIN THIS DOCUMENT IN THE PATIENT'S MEDICAL RECORD

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*A detailed description of these exchange entities is included on page 4 of this form.

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*Greater Houston Healthconnect is a non-profit organization that provides a secured electronic network for Healthconnect participants, including doctors' offices, hospitals, labs, pharmacies, radiology centers and payers of health claims such as health insurers to share your PHI. A list of current Healthconnect participants is available at www.ghhconnect.org. When you join Healthconnect, your doctors can electronically search all Healthconnect participants for your PHI and use it while treating you.
Healthconnect does not change who gets to see your information – it allows your information to be shared in a new way. All Health connect participants must protect your privacy in accordance with state and federal laws.

Carequality, Inc. is a 501(c)(3) non-profit and a national-level, consensus-built, interoperability framework to enable exchange between and among health information networks and service platforms. Carequality supports secure access to health information across diverse networks, including those operated by electronic health record vendors, record
locator service providers, health information exchanges, and others. The connectivity is governed by technical and policy agreements developed and maintained by a broad group of industry and government stakeholders.

Commonwell provides participating practitioners access to past and present medical information to make better decisions and better coordinate care across your care teams. To view participating provider sites, visit the Commonwell website at www.commonwellalliance.org/providers.