care@care
Insurance Company, Inc.

Member Consent for Release of Protected Health Information

Use this form to allow Care N' Care to share your protected health information (also known as PHI) with an individual or organization.

Member who is giving consent

This form can only be used for one member. Please submit a separate form for each member.

Name _____ Date of Birth _____

Enrollee ID (number on ID card beginning with 1 to 3 letters) _____

Address _____ Daytime Phone _____

City _____ State _____ Zip _____

Protected health information to be shared (check one)

- ☐ Any and all information (including personal, health, demographic, claims, billing, and medical records)
- ☐ Only limited information (such as for specific treatments, dates of service, or billing details)
- ☐ Please Describe _____

Please check below if you would also like to include any of the following highly protected information (known as Super PHI):

- ☐ Substance abuse records (including alcoholism)
- ☐ AIDS or HIV treatment records
- ☐ Mental health services (does not include psychotherapy notes)

Person or organization that may receive your information

Note: if information is shared with a person or organization that is not legally required to obey privacy laws, the information may be shared with others and is no longer protected.
Print first and last name for a person, and the most detailed name possible for an organization(for example, hospital name and department).

Recipient's full name: _____

Please check the box below describing the person or organization's relationship to you.

- ☐ Family Member
- ☐ Friend
- ☐ Doctor or health care provider
- ☐ Other (describe): _____

Recipient's full name: _____

Please check the box below describing the person or organization's relationship to you.

- ☐ Family Member
- ☐ Friend
- ☐ Doctor or health care provider
- ☐ Other (describe): _____

Form continues on page 2.

Recipient's full name: _____

Please check the box below describing the person or organization's relationship to you.

- ☐ Family Member
- ☐ Friend
- ☐ Doctor or health care provider
- ☐ Other (describe): _____

Expiration and cancellation

This permission will expire (check one box only):

- ☐ On this date (month, day, and year MM/DD/YYYY) _____
- ☐ When canceled, or upon my death.

I understand that I can cancel this authorization at any time by submitting a written request on a standard form, available online at cnchealthplan.com or by calling the number listed on the back of my ID card. I understand that cancellation will not apply to information that has been released by this authorization.

Authorization and signature

I allow the use and disclosure of my protected health information as described above. This information is being released at my request. I understand that my treatment, payment, enrollment or eligibility for benefits does not depend on whether I sign this authorization.

Signature of member

Sign Here: _____ **Date:** _____

IMPORTANT: Please read the form over carefully and be sure you have included all necessary information.

We cannot take additional information by phone, fax, or email. If information is missing we will have to contact you and request a new form.

Mail completed consent form to:

Care N' Care Insurance Company
1603 Lyndon B. Johnson Freeway, Suite 300
Farmers Branch, TX 75234

or fax to: 817-687-4103

Care N' Care Insurance Company, Inc. (Care N' Care) is an HMO and PPO plan with a Medicare contract. Enrollment in Care N' Care depends on contract renewal. ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call 1-877-374-7993 (TTY 711). ATENCIÓN: si habla español, tendrá a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-374-7993 (TTY 711).