Deaconess OneCare HEALTH PLAN

Authorization to Share Personal Information

Send your completed form to: Attn: Member Services, Deaconess OneCare Health Plan PO Box 407 Columbus, IN 47202-0407
Or fax to: 812-378-7048

Member Information (Required)

Member ID number

Member date of birth MM / DD / YYYY

Member first name

Middle initial

Member last name

Member permanent address

City

State

ZIP code

If your permanent address is outside of the plan's service area, you will lose your plan.

Date at permanent address MM / DD / YYYY

Daytime telephone number ___ – ___ – ____

Evening telephone number ___ – ___ – ____

Email address

Please Note: This form does not give permission to the person or organization named below to:

- Change the plan you are enrolled in, or
- Represent you in a claims appeal, or
- Decide what kind of care you get

Who Do You Want to Share Your Information With? (Required)

Name

Address

City	State	ZIP code

Member ID (required for portal access of your records)

Your Permission (Required)

Personal health information is protected by the Health Insurance Portability and Accountability Act (HIPAA).

When you sign this form, you agree to the following: Deaconess OneCare Health Plan and its related companies have permission to give my personal health information to the person or organization listed in the section above. Records may contain information on specific medical care or services I received. They may also contain information created by others. The information may include medical, claim or benefit records.

Sign Here Date MM / DD / YYYY

☐ Check here, and complete the Legal Representative Information section if you are signing as a legal representative.

If the member can only sign with an "X," a witness will also need to sign the form. This witness can't be any person or organization receiving the member's personal health information.

Witness Sign Here Date MM / DD / YYYY

Legal Representative Information

If the member can't sign this form, a legal representative may sign, complete and return this form for the member. A legal representative is someone who has the legal right to sign for the member. **Please attach proof that you are the member's legal representative (for example, Power of Attorney). We can't accept this form without it.**

First name		Middle initial
Last name		
Address		
City	State	ZIP code
Telephone number ___ - ___ - ____		

If you have any further questions, please call Deaconess OneCare Health Plan at 844.378.7103.

You can use this form to give permission to Deaconess OneCare Health Plan to share your personal health information with a trusted person or organization you select. Please complete and sign this form.

How long does this permission last? Permission to share your records ends on your last day as a member of the plan, or when you write to us and tell us to end it.

Can I change my mind and "take back" this permission? You can tell us to stop sharing your information in the future.

How do I end permission to share my personal health information? You will need to write to us to request an end to your permission. Be sure to sign and date it. You can mail or fax your request. Please keep a copy for your records.

Who can view my personal health information through the member web portal? Only other members of Deaconess OneCare Health Plan who have your written permission can view your information on the member portal. Be sure to include on this form your member ID number and that of the person you wish to share information with.