Authorization to Use and Disclose Health Information

Notice to Member:

- Completing this form will allow Delaware First Health to (i) use your health information for a particular purpose, and/or (ii) share your health information with the individual or entity that you identify on this form.
- You do not have to give permission to use or share your health information. Your services and benefits with Delaware First Health will not change if you do not submit this form.
- If you want to cancel this authorization form, send us a written request to revoke it at the address on the bottom of this page. A revocation form can be provided to you by calling Member Services at the phone number on the back of your member ID card.
- Delaware First Health cannot promise that the person or group you allow us to share your health information with will not share it with someone else.
- Keep a copy of all completed forms that you send to us. We can send you copies if you need them.
- If you need help, contact Member Services at the phone number on the back of your member ID card.
- Fill in all the information on this form. When finished, mail the form and any supporting documentation to
  Delaware First Health
  ATTN: Compliance/Privacy Department
  750 Prides Crossing, Suite 200
  Newark, DE 19713

Aviso para el miembro:

- Al completar este formulario, autoriza a Delaware First Health (i) a utilizar su información de salud para un propósito en particular o (ii) a compartir su información de salud con la persona o entidad que indica en este formulario.
- No tiene la obligación de autorizar el uso o la divulgación de su información de salud. Los servicios y beneficios que recibe de Delaware First Health no cambiarán si decide no enviar este formulario.
- Si desea cancelar la autorización otorgada en este formulario, envíenos una solicitud por escrito para revocarla a la dirección que se indica al final de esta página. Pueden proporcionarle un formulario de revocación si llama a Servicios al Miembro al número de teléfono que aparece al dorso de su tarjeta de identificación (ID) de miembro.
- Delaware First Health no puede garantizar que la persona o el grupo con quien nos permite compartir su información de salud no la divulguen a otra persona.
- Guarde una copia de todos los formularios completos que nos envía. Podemos enviarle copias si las necesita.
- Si necesita ayuda, comuníquese con Servicios al Miembro al número de teléfono que aparece al dorso de su tarjeta de identificación (ID) de miembro.
- Complete toda la información solicitada en este formulario. Cuando termine, envíe el formulario y cualquier documentación de respaldo por correo a
  Delaware First Health
  ATTN: Compliance/Privacy Department
  750 Prides Crossing, Suite 200
  Newark, DE 19713

DelawareFirstHealth.com

CAD_144905E_State Approved 04152023
© 2024 Delaware First Health. All rights reserved.
DE4CADFRM44905E_0124
PSHP_082120_480

PLEASE READ THE INSTRUCTIONS CAREFULLY AND COMPLETE THE FORM BELOW. INCOMPLETE FORMS CANNOT BE ACCEPTED.

1 MEMBER INFORMATION:

Member Name *(print)*: ______________________________

Member Date of Birth: ____________ Member ID Number: ____________

2 I GIVE DELAWARE FIRST HEALTH PERMISSION TO USE MY HEALTH INFORMATION FOR THE PURPOSE IDENTIFIED OR TO SHARE MY HEALTH INFORMATION WITH THE PERSON OR GROUP NAMED BELOW. THE PURPOSE OF THE AUTHORIZATION IS *(check one option below)*:

☐ to allow Delaware First Health to help me with my benefits and services, **OR**

☐ to permit Delaware First Health to use or share my health information for ____________.

3 PERSON OR GROUP TO RECEIVE INFORMATION *(add more Persons or Groups on next page)*:

Name (person or group): ______________________________

Address: ______________________________

City: ____________ State: ____________ Zip: ____________ Phone: ____________

4 I AUTHORIZE DELAWARE FIRST HEALTH TO USE OR SHARE THE FOLLOWING HEALTH INFORMATION *(NOTE: Select the first statement to release ALL health information or select the below statement to release only SOME health information. **Both CANNOT be selected**.)*

☐ **All of my health information INCLUDING:** Genetic information, services or test results; HIV/AIDS data and records; mental health data and records (but not psychotherapy notes); prescription drug/medication data and records; and drug and alcohol data and records (please specify any substance use disorder information that may be disclosed); ____________

OR

☐ **All of my health information EXCEPT** *(check only the boxes below that apply)*:

☐ Genetic information, services or tests

☐ AIDS or HIV data and records

☐ Mental health data and records (but not psychotherapy notes)

☐ Drug and alcohol data and records

☐ Prescription drug/medication data and records

☐ Other: ____________

5 THIS AUTHORIZATION ENDS ON THIS DATE/EVENT: ____________ *Date this authorization ends unless cancelled. If this field is blank, the authorization expires one year from the date of the signature below.*

---

6 MEMBER OR LEGAL REPRESENTATIVE SIGNATURE: ______________________________

DATE: ____________

IF LEGAL REPRESENTATIVE - Relationship to Member: ______________________________

*If you are the Member's legal or personal representative, **you must send us copies of relevant forms**, such as power of attorney or order of guardianship.*

MAIL COMPLETED AUTHORIZATION FORM AND ANY SUPPORTING DOCUMENTATION TO
Delaware First Health, ATTN: COMPLIANCE/PRIVACY DEPARTMENT
750 Prides Crossing, Suite 200, Newark, DE 19713

ADDITIONAL INDIVIDUAL PERSON(S) OR GROUP(S) TO RECEIVE INFORMATION:

NOTE: If you are consenting to disclose any substance use disorder records to a recipient that is neither a third party payor nor a health care provider, facility, or program where you receive services from a treating provider, such as a health insurance exchange or a research institution (hereafter, "recipient entity"), you must specify the name of an individual with whom or the entity at which you receive services from a treating provider at that recipient entity, or simply state that your substance use disorder records may be disclosed to your current and future treating providers at that recipient entity.

Name (individual or entity): ______________________________

Address: ______________________________

City: ____________ State: ____________ Zip: ____________ Phone: ____________

Name (individual or entity): ______________________________

Address: ______________________________

City: ____________ State: ____________ Zip: ____________ Phone: ____________

Name (individual or entity): ______________________________

Address: ______________________________

City: ____________ State: ____________ Zip: ____________ Phone: ____________

Name (individual or entity): ______________________________

Address: ______________________________

City: ____________ State: ____________ Zip: ____________ Phone: ____________

Name (individual or entity): ______________________________

Address: ______________________________

City: ____________ State: ____________ Zip: ____________ Phone: ____________

Name (individual or entity): ______________________________

Address: ______________________________

City: ____________ State: ____________ Zip: ____________ Phone: ____________

Name (individual or entity): ______________________________

Address: ______________________________

City: ____________ State: ____________ Zip: ____________ Phone: ____________

Name (individual or entity): ______________________________

Address: ______________________________

City: ____________ State: ____________ Zip: ____________ Phone: ____________