# Authorization to Use and Disclose Health Information

## NOTICE TO MEMBER

- This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.
- Completing this form will allow Iowa Total Care to:
  (i) use your health information for a particular purpose, and/or
  (ii) share your health information with the person or group that you identify on this form.
- You do not have to sign this form or give permission to use or share your health information. Your services and benefits with Iowa Total Care will not change if you do not sign this form.
- If you want to cancel this authorization form, send us a written request to revoke it. Mail it to the address at the bottom of page 2. A revocation form can also be requested by calling Member Services: 1-833-404-1061 (TTY: 711). It is also available on the Iowa Total Care website under Member Resources > Member Handbook, Manuals & Forms.
- Iowa Total Care 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 also send you copies if you need them.
- Mail your completed form to the address at the bottom of page 2.

**MEMBER INFORMATION:**

Member Name (*print*): _____

Member Date of Birth: _____Member ID Number:_____

**I give Iowa Total Care 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:**

☐ to allow Iowa Total Care to help me with my benefits and services, **OR**

☐ to permit Iowa Total Care to use or share my health information for _____

**PERSON OR GROUP TO RECEIVE INFORMATION (*add additional Persons or Groups on page 2*):**

Name (Person or Group): _____
Address: _____
City: _____State: _____Zip:_____Phone: (_____) _____

**I AUTHORIZE IOWA TOTAL CARE TO USE OR SHARE THE FOLLOWING HEALTH INFORMATION:**

☐ **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 all boxes that apply*)**:**

- ☐ Genetic information, services or tests
- ☐ AIDS or HIV data and records
- ☐ Drug and alcohol data and records
- ☐ Mental health data and records (but not psychotherapy notes)
- ☐ Prescription drug/medication data and records
- ☐ Other: _____

**Authorization End Date:** _____/_____/_____ (*date the authorization ends or five years, whichever is sooner, unless cancelled or revoked)*

**Member Signature:**_____ **Date:**_____/_____/_____
*(Member or Legal Representative sign here)*

**Relationship to Member**: _____

If you are the Member's personal representative, please mail or fax copies of those forms (such as power of attorney or order of guardianship) to:

Iowa Total Care Quality Improvement Department
1080 Jordan Creek Parkway, Suite 100S
West Des Moines, IA 50266
Fax: 1-833-809-3868

**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 healthcare 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 (Person or Group): _____
Address: _____
City: _____State: _____Zip:_____Phone: (____) _____

Name (Person or Group): _____
Address: _____
City: _____State: _____Zip:_____Phone: (____) _____

Name (Person or Group): _____
Address: _____
City: _____State: _____Zip:_____Phone: (____) _____

***Return completed form by mail or fax:*** Iowa Total Care Quality Improvement Department
1080 Jordan Creek Parkway, Suite 100S
West Des Moines, IA 50266
Fax: 1-833-809-3868

Iowa Total Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. | Iowa Total Care cumple con las leyes federales de derechos civiles aplicables y no discrimina en base a la raza, el color, el país de origen, la edad, la discapacidad o el sexo.

Language assistance services, auxiliary aids and services, larger font, oral translation, and other alternative formats are available to you at no cost. To obtain this, please call 1-833-404-1061 (TTY: 711). | Usted tiene a su disposición, sin costo alguno, servicios de asistencia lingüística, ayudas y servicios auxiliares, material en letra grande, traducción oral y otros formatos alternativos. Para obtener estos servicios, llame al 1-833-404-1061 (TTY: 711). |
我们免费为您提供语言协助服务、辅助设施和服务、更大字体、口头翻译和其他替代格式。如需获得此服务，请致电 1-833-404-1061 (TTY: 711) 。