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:
  - use your health information for a particular purpose, and/or
  - obtain from or 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.
- 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:

Iowa Total Care Attn: ROI Processing Team
1080 Jordan Creek Parkway, Suite 100S
West Des Moines, IA 50266
Fax: 1-833-847-3026

Autorización para usar y divulgar información de salud

AVISO PARA EL AFILIADO

- Este aviso describe cómo se puede usar y divulgar su información médica y cómo puede tener acceso a esta información. Revíselo con atención.
- Completar este formulario le permitirá a Iowa Total Care:
  - usar su información de salud para un propósito particular, y/o
  - obtener o compartir su información de salud con la persona o el grupo que usted identifique en este formulario.
- No tiene que firmar este formulario ni dar permiso para usar o compartir su información de salud. Sus servicios y beneficios con Iowa Total Care no cambiarán si no firma este formulario.
- Si desea cancelar este formulario de autorización, envíenos una solicitud por escrito para revocarlo. Envíela por correo a la dirección que figura en la parte inferior de la página 2. También se puede solicitar un formulario de revocación llamando a Servicios para afiliados: 1-833-404-1061 (TTY: 711). También está disponible en el sitio web de Iowa Total Care en Member Resources (Recursos para afiliados) > Member Handbook, Manuals & Forms (Manual del afiliado, otros manuales y formularios).
- Iowa Total Care no puede prometer que la persona o el grupo con quien nos permitió compartir su información de salud no la comparta con alguien más.

- Guarde una copia de todos los formularios completados que nos envíe. También podemos enviarle copias si las necesita.
- Si necesita ayuda, comuníquese con Servicios para afiliados llamando al número de teléfono que figura en el reverso de su tarjeta de identificación de afiliado.
- Complete toda la información en este formulario. Cuando haya terminado, envíe por correo el formulario y cualquier documentación de respaldo a:

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West Des Moines, IA 50266
Fax: 1-833-847-3026

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 IOWA TOTAL CARE PERMISSION TO USE MY HEALTH INFORMATION FOR THE PURPOSE IDENTIFIED OR TO BOTH OBTAIN FROM OR RELEASE MY HEALTH INFORMATION WITH THE PERSON OR GROUP NAMED BELOW.**

The purpose of the authorization is *(check one option below):*

☐ 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 _____

3 **PERSON OR GROUP TO BOTH OBTAIN FROM OR RELEASE MY INFORMATION (*add additional Persons or Groups on page 2*):**

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

4 **I AUTHORIZE IOWA TOTAL CARE 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 andrecords; 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:_____

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

6 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 | Attn: ROI Processing Team |1080 Jordan Creek Parkway, Suite 100S | West Des Moines, IA 50266 | Fax: 1-833-847-3026

ADDITIONAL INDIVIDUAL PERSON(S) OR GROUP(S) TO OBTAIN OR RELEASE 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: (____) __________

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: (____)__________

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 Attn: ROI Processing Team
1080 Jordan Creek Parkway, Suite 100S West Des Moines, IA 50266
Fax: 1-833-847-3026

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) 。