WELLCARE HIPAA RELEASE OF INFORMATION FORM

This form is used to confirm a Member's permission that the Health Plan* may discuss or disclose Protected Health Information (PHI) to a particular person who acts as the Member's Personal Representative. Use of the PHI is strictly limited to that purpose.

Section A – Member Information

By signing this form, I understand and agree that the Health Plan may release my PHI (defined in Section B) to my Personal Representative named in Section C.

Print Name of Member: _____ Date of Birth (mm/dd/yyyy): _____

Address: _____

Telephone Number: _____ Member ID Number: _____

Medicare Number: _____ Medicaid Number: _____

*The Health Plan is WellCare Health Plans, Inc. ("WellCare"). This release applies to each of the following Health Plans: Easy Choice Health Plan, Inc., Exactus Pharmacy Solutions, Inc., WellCare of Florida, Inc. operating in Florida as HealthEase and Staywell, WellCare of New York, Inc., WellCare of Connecticut, Inc., WellCare of Louisiana, Inc., WellCare Prescription Insurance, Inc., Harmony Health Plan of Illinois, Inc. operating in Missouri as Harmony Health Plan of Missouri, Harmony Health Plan of Illinois, Inc., WellCare of Georgia, Inc., WellCare of Ohio, Inc., WellCare Health Insurance of Arizona, Inc. operating in Hawaii as 'Ohana Health Plan, Inc., WellCare of Texas, Inc. operating in Arizona as WellCare of Arizona, Inc., WellCare Health Insurance of Kentucky, Inc. operating in Kentucky as WellCare of Kentucky, Inc., WellCare of South Carolina, Inc., Missouri Care, Incorporated, and WellCare Health Plans of New Jersey, Inc.

This release does not provide your Personal Representative with any authority to make any treatment or health care decisions. If you want a Health Care Power of Attorney or a Living Will, or you want to appoint a Health Care Proxy, talk to your attorney or your doctor. Also, the Health Plan will not condition benefits payments, enrollment, or eligibility for benefits on the execution of this form.

Section B – Scope of Information

Information Authorized for Use or Disclosure:

- PHI includes, but is not limited to, premium information, eligibility status, claims history, identification of treating providers of care, diagnoses, procedures, and demographic information.
- This information may include diagnoses and/or treatment for alcohol and/or drug abuse; AIDS/AIDS Related Complex (ARC) and HIV diagnoses and/or treatment; and diagnoses and/or treatment relating to other communicable diseases, subject to any applicable state law restrictions.
- This authorization does not cover disclosure of psychotherapy notes.

Section C – Authorized Use and/or Disclosure

Intended Use or Disclosure:
I understand that the Health Plan's general policy is not to disclose my personal health information to other parties, except those directly involved in my care, without my written authorization or as permitted or required by law. For this reason, I authorize you to discuss and disclose my PHI, as described in Section B, to the person(s) named below. I also understand that if my Personal Representative is not a health care provider or another entity subject to federal or applicable state privacy laws, those privacy laws may no longer protect my PHI and my Personal Representative (if applicable) may further disclose my PHI without my authorization. I acknowledge that my authorization is voluntary.

Personal Representative:

Name: Date of Birth (mm/dd/yyyy):

Address:

Relationship to You: Telephone Number:

Section D – Expiration and Revocation

This authorization to release information to my Personal Representative will automatically expire two (2) years following the termination of my enrollment with the Health Plan.

I understand that I have the right to revoke or end this authorization at any time. I understand that, if I do not wish the person named in Section C to remain my Personal Representative, I must revoke this authorization **in writing** by giving written notice of my decision to the Health Plan contact listed below. I may call the contact listed below and request a Revocation of Authorization Form to assist me in submitting my written request. In addition, I understand that this revocation will not revoke any other authorizations to release information that I have provided to the Health Plan. Revocation of this authorization will not affect any action that the Health Plan has taken, or any PHI that the Health Plan has already released, based upon this authorization before the Health Plan has actually received my request to revoke it.

Contact the Health Plan:

- For questions by telephone, call the toll-free number on your membership identification card.
- Submit the request to revoke your authorization by mail to:
  WellCare Health Plans, Inc.
  Attention: Customer Service – Authorization for PHI
  P.O. Box 31370
  Tampa, FL 33631-3370
  Fax: 813- 464-8413

Please be sure to include your name and member ID number.

Section E – Signature/Authorization

I have had full opportunity to read and consider the content of this WellCare HIPAA Release of Information Form. I confirm that this authorization is consistent with my request of the Health Plan. I understand that, by signing this form, I am confirming my authorization that the Health Plan may use and/or disclose my PHI to the person named in Section C for the purpose described above. I also confirm that a facsimile copy of this form is acceptable.

_____ _____

Signature of Member or Personal Representative (if applicable) Date

_____

Print Name of Member or Personal Representative (if applicable)

_____

Relationship of Personal Representative (if applicable)

Please return the signed WellCare HIPAA Release of Information Form to the contact listed in Section D. You are entitled to a copy of this form after you sign it.