ConnectiCare®
VIP Medicare Plans

PO Box 4050
Farmington, CT 06034-4050
1-800-CCI-CARE (1-800-224-2273)

AUTHORIZATION FORM

I, _____hereby authorize ConnectiCare and its affiliates, its employees and agents (collectively "ConnectiCare"), to release to _____ **[insert full name of person/organization]** my personal health information maintained by ConnectiCare (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) **except** the following information about me: _____ **[DESCRIBE INFORMATION NOT TO BE DISCLOSED, IF ANY]** for the purpose of _____ **[INSERT SPECIFIC PURPOSE].**

I understand that any personal health information or other information released to the person or organization identified above may be subject to redisclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

This authorization is valid from the date of my/my representative's signature below and shall expire the earlier of _____ **[INSERT DATE/EVENT UPON WHICH THIS AUTHORIZATION EXPIRES]** or the date my coverage ends with ConnectiCare**.** I understand that I have a right to revoke this authorization by providing written notice to ConnectiCare. However, this authorization may not be revoked if ConnectiCare, its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

Name of Member: _____ Member ID#: _____

Signature of Member: _____

Date:_____

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Name of Member: _____

If applicable, Legal Representatives (including parent/guardian of a minor child) sign below:
By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

Name of Legal Representative : _____

Signature of Legal Representative: _____

Relationship to Member: _____

Date: _____

Name of Witness: _____

Signature of Witness: _____