Care and communication on your terms

Your privacy and well-being are important to us. There may be times when you want a family member or friend to talk to CarePlus on your behalf.

To make that possible, you must first complete a consent for release of protected health information form. This form will allow you to choose a trusted individual who can have access to your protected health information. We would consider this person to be your family or friend caregiver.

This is not a power of attorney (POA). To have someone help you enroll or to request account changes or updates, you must submit a POA or other authorization under state law to allow them to act on your behalf. You can submit POA and PHI consent forms together.

If you complete the PHI form and grant authorization to someone, we will consider that individual your caregiver who can:

- Speak to CarePlus on your behalf about the plan—but may not make or request any account changes or updates (unless they are your POA or have other legal authorization from the state to act on your behalf)
- Keep track of your benefits and claims
- Get answers to healthcare coverage questions
- Receive helpful information and advice on caregiving from CarePlus

How to get started*

You have three options for completing and submitting your consent form.

1. If you have a MyCarePlus account or plan to create one after enrolling, you can complete a consent form online from the “My Resources” page.
2. Your agent can utilize one of our sales systems to help you complete a consent form electronically as part of your enrollment.
3. Complete the paper form included with this packet (after you have submitted your application and received your CarePlus member ID card).

You don’t need to use this consent form to authorize an individual if you are also submitting a POA or other legal authorization for the same individual.

*If you have previously submitted a consent form for this individual, you do not need to submit again at this time. We will notify you if your consent is due to expire.

Consent for release of protected health information

Member information (person whose information will be released):

Name: _____ Date of birth: ____ / ____ / ____
First Middle Last Month Day Year

Address: _____
Street City State ZIP

Member ID: _____ Phone #: _____ ☐ Home ☐ Cell*

I understand that this authorization will allow CarePlus and its affiliates to use or disclose the protected health† information (PHI) described below:

I understand that this authorization will allow CarePlus and its affiliates to use or disclose any protected health** information CarePlus and its affiliates maintain, including mental health, HIV, health status, or substance abuse records. This also includes sharing information on mail-order pharmacy, wellness products, and health programs with the person being authorized.

This information may be disclosed to, and used by, the following individuals or organizations:

Name: _____ Date of birth: ____ / ____ / ____
Month Day Year

Address: _____
Street City State ZIP

Email: _____ Phone #: _____
☐ Home ☐ Cell*

Relationship: ☐ Spouse ☐ Sibling ☐ Parent ☐ Child ☐ Agent/Broker ☐ Friend ☐ Organization

I understand:

- I am not required to fill out this consent and CarePlus cannot base decisions regarding treatment, payment, enrollment or eligibility for benefits on whether I submit it.
- Disclosures may include information from past, present, and/or future treating providers.
- This consent is valid until I cancel my CarePlus membership. I can cancel my consent at any time through my MyCarePlus account or by submitting a written notice to CarePlus.
- If I cancel consent, it will not apply to any information previously released with this authorization. Once information is shared, CarePlus cannot prevent the person or organization who has access to it from sharing that information with others, and this information may not be protected by federal privacy regulations.
- I am not required to sign this consent and CarePlus cannot base decisions regarding treatment or payment on whether I sign it.

Member or Legal Representative signature _____

☐ Member ☐ Legal Representative Date: ____ / ____ / ____

Please note: Legal representatives must attach copies of authorization as required by law. Examples include healthcare power of attorney, healthcare surrogate, living will or guardianship papers.

After you complete and sign the form, please fax it to 1-855-819-8679. Or, if you prefer, mail your completed form to: **CarePlus Health Plans, Inc., P.O. Box 14733, Lexington, KY 40512-4642**.

*By giving your cell phone number, you give CarePlus permission to make calls to your cell.
†Health includes Medical, Dental, Pharmacy, Behavioral Health, Vision, Long-Term Care.
CarePlus will follow the more stringent of all federal and state laws and regulations.

CarePlus HEALTH PLANS