Consent for Release of Protected Health Information (PHI)

This form is used to authorize consent for CarePlus to communicate PHI to the person(s) or organization below.

Member information (person whose information will be released):

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

Address: _____
Street City State ZIP Code

Member ID: _____ Telephone number (with area code): _____
☐ Home ☐ Cell*

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: _____ Relationship: _____

Address: _____ City: _____

State: _____ ZIP Code: _____ Phone: _____
☐ Home ☐ Cell*

Name: _____ Date of birth: _____ Relationship: _____

Address: _____ City: _____

State: _____ ZIP Code: _____ Phone: _____
☐ Home ☐ Cell*

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.

Date: _____

Signature of Member or Legal Representative: _____
☐ Member ☐ Legal Representative

Please note: Legal representatives must attach copies of authorizations 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., PO 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 information.

If you have any questions, please call Member Services at 1-800-794-5907 (TTY: 711). From October 1 - March 31, we are open 7 days a week; 8 a.m. to 8 p.m. From April 1 - September 30, we are open Monday - Friday, 8 a.m. to 8 p.m. You may always leave a voicemail after hours, Saturdays, Sundays, and holidays and we will return your call within one business day.