WRITTEN AUTHORIZATION FORM

In accordance with the HIPAA Privacy Laws, we cannot release your health information without your written authorization. If you want Essence to disclose your information to another party, please complete, and sign this Authorization form. You must complete all of the sections of this Authorization in order for it to take effect.

A. Member Name_____ **ID#** _____

By signing below, Member authorizes and requests Essence to release information to:

B. _____ _____
Name of Recipient **Address**

C. This Authorization applies to:

- ❑ All services and health information (all dates and all providers)

- ❑ Limited Information (if limited, please identify which information should be shared below)
  - ❑ One service only: _____
    Date of service_____ Doctor/Supplier _____
  - ❑ Information about your Medicare eligibility
  - ❑ Information about your Medicare claims
  - ❑ Information about plan enrollment (e.g. drug or MA Plan)
  - ❑ Other/Special Instructions: _____

D. State how long you wish this Authorization to be in effect:

- ❑ Disclose my health information indefinitely
- ❑ Disclose my health information until Specific Date or Event: _____

If you have any questions about this form or need additional assistance, including free language translation services, you may contact Essence Healthcare (HMO) Customer Service 8:00am - 8:00pm, 7 days a week at 314-209-2700 or 866-597-9560. TTY users should call 711. You may receive a messaging service on weekends and holidays from February 15 through September 30. Please leave a message and your call will be returned the next business day.

E. Member Signature

This Authorization is voluntary and refusal to sign this Authorization will have no effect on your enrollment, eligibility for benefits, or the amount Essence pays for your health services. You may revoke this Authorization by sending a written revocation to the address at the end of this form. A revocation will not apply to information already released based on your permission. The information disclosed by Essence under this Authorization may be re-disclosed by the recipient and no longer protected by federal or state law.

_____ _____
Signature of Member **Date**

(If signed by someone other than Member, see Section F on next page)

Essence Healthcare is an HMO with a Medicare Contract. Enrollment in Essence Healthcare depends on contract renewal
17-052_Y0027

F. Legal Representative

If this Authorization is signed by a legal representative or someone other than the Member identified in Section A above, complete the following:

By signing this form, I represent that I am the legal representative of the Member identified in Section A and will provide Essence with 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: _____

Date: _____

Relationship to Member: _____

Return this form to: **ESSENCE HEALTHCARE**
PO Box 12488, St. Louis, MO 63132-0188