HIPAA 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#** _____

Authorizes and requests Essence to release information to:

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

C. **This Authorization applies to**:
- ❑ One service only:
  Date of service_____ Doctor/Supplier _____
- ❑ All services (all dates and all providers)
- ❑ All services from specific doctor or supplier: Doctor/Supplier _____
- ❑ Medicare eligibility information
- ❑ Information on other health coverage: _____
- ❑ Deductible information for (year): _____
- ❑ Copy of Explanation of Benefits for:
  Date of service_____ Doctor/Supplier _____

D. **State how long you wish this Authorization to be in effect:**
- ❑ One time release
- ❑ Until Specific Date or Event: _____
- ❑ Ongoing release until otherwise revoked. A revocation will not apply to information already released.

If you have any questions or need additional assistance please contact Essence Healthcare (HMO) Customer Service 8:00 AM - 8:00 PM 7 days a week at 314-209-2700 or 866-597-9560. TTY users should call the Relay Service at 711. Also, if you need help understanding the information in this letter/form/document/correspondence, please contact customer service at the number above for free language translator services. You may receive a messaging service on weekends and holidays from April 1 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 the health services you receive. You may revoke this Authorization by sending a written revocation to the address at the end of this form. 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)

Essence Healthcare is an HMO with a Medicare Contract. Enrollment in Essence Healthcare depends on contract renewal
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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 5907, Troy, MI 48007