Authorization for Sharing Health Information

PerformCARE®

[Please print]

This form is used to share your protected health information ("PHI") where required by federal and state privacy laws. Your authorization allows PerformCare to share your PHI with the person(s) or organization(s) that you choose. You can also choose to allow the person(s) or organization(s) to share your PHI with PerformCare. You can cancel this authorization at any time by submitting a request to PerformCare. Contact Member Services at **1-877-652-7624 (TTY 1-866-896-6975)** for further instructions.

Part A. Member Information: (individual whose PHI will be shared)

Member First Name:		Middle Initial:
Last Name:	Member ID (see ID card):	
Member Street Address:		
City:	State:	ZIP code:
Member Date of Birth:	Daytime Telephone Number (with area code):	

Part B. Recipient: (person or organization that will receive your PHI)

The following individual or organization has the right to receive my PHI:

Do you want the following individual or organization to also share your PHI with us? ☐ Yes ☐ No

First Name:	Last Name:	
Organization Name (if applicable)		
Address:		
City:	State:	ZIP code:
Telephone Number (with area code):		
Relationship to Member in Part A:		

Part C. Description of the PHI to be Shared:

Tell us what types of PHI can be shared. You can check as many boxes as you want. At least one box must be selected.

☐ **Entire record.** All PHI related to the provision of and payment for my health care benefits and services. Federal law requires a separate authorization to share psychotherapy notes.

☐ **Special records. <u>Some laws require you to give specific permission to share certain PHI. Please check the boxes below for PHI that is OK to share</u>.** By checking these boxes, you give permission for all your records containing that type of PHI to be shared. If you only want to authorize sharing of a subset of records, such as records about only one diagnosis, fill out the "Only limited information" section below.

- ☐ Genetic information
- ☐ HIV/AIDS
- ☐ Substance or alcohol use
- ☐ Mental/behavioral health (including inpatient treatment)
- ☐ Sexually transmitted disease
- ☐ Abortion and family planning
- ☐ Communicable diseases
- ☐ Information you have asked us to treat confidentially

☐ **Only limited information.** In the box below, describe the PHI you want shared. Examples:

- The claim related to my service on [date].
- Appeal information related to my claim on [date].

Please describe the information you want shared:

Part D. Purpose of this Authorization

This authorization is valid for sharing of PHI for the following purposes. (Please check one or both boxes.)

☐ To help diagnose, treat, manage and/or pay for my health needs.

OR

☐ For the following reason:

This authorization shall be invalid if used for any purpose other than the purpose(s) stated above.

Part E. Expiration Date of this Authorization

This authorization is valid for sharing of PHI for the following purposes. (Please check one box.)

☐ I want the authorization to expire one (1) year after my coverage with PerformCare ends. (See information below)*

OR

☐ Upon the following date, event or condition*:

* PerformCare must be notified of the event/condition to cancel this authorization. In North Carolina and New Jersey, this authorization automatically expires one year after the date it was signed, unless you choose an earlier date. In New Hampshire, the authorization automatically expires two years after the date it was signed, unless you choose an earlier date. In Louisiana, if you are requesting the sharing of genetic information, the authorization expires sixty days after the date it was signed, unless you choose an earlier date. In the District of Columbia, if you are requesting the sharing of mental health information, the authorization automatically expires one year after the date it was signed, unless you choose an earlier date.

Part F. Approval: (You OR your Personal Representative must sign and date this form in order for it to be complete.)

I understand that this authorization for sharing my PHI is voluntary and is not a condition of enrollment in PerformCare, eligibility for benefits, or payment of claims. I understand that I may cancel this authorization at any time by submitting a request to PerformCare, and that cancelling this authorization will not affect any action taken pursuant to the authorization prior to my request to cancel. I also understand that if I cancel this authorization, I should separately notify the individual(s) or organization(s) listed in Part B above if I wish for those individual(s) or organization(s) to no longer share my PHI. I also understand that if the person or organization I authorize to receive my PHI described above is not subject to federal or state health information privacy laws, they may further share my PHI and it may no longer be protected by federal or state privacy laws. I also understand that I or my personal representative have a right to receive a copy of this form and to review my PHI that may be shared because of this authorization.

Member Signature: By signing below, I authorize the sharing of my PHI as described above.	
Signature of member (age 14 or older) or parent signature:	Date:

Personal Representative Information: By signing below, I authorize the sharing of PHI of the member as described above. (A Personal Representative is a person who has the legal authority to act on behalf of an individual, such as a parent of a minor. A copy of a Power of Attorney or other legal document must be on file at PerformCare or submitted with this form.)	
Printed Name of Personal Representative:	
Address of Representative:	
Description of Personal Representative's Authority:	
Signature of Personal Representative:	
Date:	Telephone Number:

Return the Completed Form to: Consent Processing Center, P.O. Box 7092, London, KY 40742-7092
Fax Number: 1-833-214-2242 (Toll Free)

Addendum to Authorization for Disclosure of Health Information

Verbal consent

We, the undersigned, attest that the member identified in Section A above is **physically unable** to sign this authorization. Verbal consent does not replace the need for documentation showing that another person is the member's personal representative, and cannot replace this documentation simply because it is inconvenient for the member to sign.

Reason:

The signatures below indicate:

- The information on this form was communicated to the member.
- The member indicated their understanding of the information in this authorization.
- The member freely gave their consent.

Method of communication to member:

☐ Phone

☐ In person

☐ Other (specify):

Witness printed name:	Witness printed name:
Witness signature:	Witness signature:
Date: / /	Date: / /

Discrimination is against the law

PerformCare complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PerformCare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

PerformCare reduces language barriers to accessing services through the New Jersey Children's System of Care by:

- Providing free aids and services to people with disabilities to communicate effectively with us, such as:
    - Written information in other formats (large print, audio, accessible electronic formats, and other formats).
    - Telecommunication devices such as Device for the Deaf (TDD) and Text Telephone (TTY) systems to enable individuals who are deaf, hard of hearing, or speech-impaired to use the phone to communicate.
- Providing language services at no cost to people whose primary language is not English, such as:
    - Qualified interpreter services.
    - Information written in other languages.

If you need these services, contact PerformCare at **1-877-652-7624** or [**TTY** (for the hearing impaired) **1-866-896-6975**]. We are available 24 hours a day, seven days a week.

If you believe that PerformCare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can submit a complaint by mail or phone, by either calling PerformCare's Quality department at **1-877-652-7624** or by writing to:

PerformCare
Attn: Quality Department
300 Horizon Center Drive, Suite 306, Robbinsville, NJ 08691

If you need help filing a complaint, PerformCare's Quality department is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW, Room 509F, HHH Building
Washington, DC 20201

1-800-368-1019, **1-800-537-7697** (**TDD**)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

Multi-language interpreter services

Attention: If you do not speak English, language assistance services are available to you at no cost. Call 1-877-652-7624 (TTY 1-866-896-6975).

Spanish: Atención: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-652-7624 (TTY 1-866-896-6975).

Portuguese: Atenção: Se fala português, encontra-se disponível serviço gratuito de intérprete pelo telefone 1-877-652-7624 (TTY 1-866-896-6975).

Arabic:
ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-652-7624 (رقم هاتف الصم والبكم: 1-866-896-6975 :TTY).

Haitian Creole: Atansyon: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-652-7624 (TTY: 1-866-896-6975).

Chinese Mandarin: 注意：如果您说中文普通话/国语，我们可为您提供免费语言援助服务。请致电：1-877-652-7624 (TTY 1-866-896-6975)。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-652-7624 (TTY 1-866-896-6975) 번으로 전화해 주십시오.

Bengali: লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১1-877-652-7624 (TTY 1-866-896-6975)।

French: Attention : si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-652-7624 (TTY 1-866-896-6975).

Vietnamese: Chú ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-652-7624 (TTY 1-866-896-6975).

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-652-7624 (TTY 1-866-896-6975) पर कॉल करें।

Chinese Cantonese: 注意：如果您使用粵語，您可以免費獲得語言援助服務。請致電 1-877-652-7624 (TTY 1-866-896-6975)。

Polish: Uwaga: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-652-7624 (TTY 1-866-896-6975).

Urdu:
توجہ فرمائیں: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-877-652-7624 (TTY: 1-866-896-6975).

Turkish: Dikkat: Türkçe konuşuyorsanız dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. 1-877-652-7624 (TTY 1-866-896-6975) numaralı telefonu arayın.

Russian: Внимание: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-652-7624 (TTY 1-866-896-6975).