Clear Spring Health

Authorization to Disclose Protected Health Information (PHI)

Use this form to authorize Clear Spring Health to use or disclose your PHI. All fields are required. Incomplete or incorrect forms will be returned.

Member Name:	**Member ID:**
Member Address:	
Member City / State / Zip:	
Member Date of Birth:	**Member Phone #:**

I hereby authorize Clear Spring Health to disclose the protected health information listed below to the following person / entity:

Name:	
Relationship To Member:	**Address:**
	City / State / Zip

Please specify what information you would like to be disclosed to the individual listed above :

- ☐ All my Protected Health Information
- ☐ *Only* my benefit(s) information
- ☐ *Only* my claim(s) information
- ☐ Other *(please describe)*:

I understand that protected health information is any information that relates to:

- My past, present, or future physical or mental health or condition;
- Health care I have received or will receive; and
- Payment for health care I have received or will receive and identifies me, or with respect to which there is a reasonablebasis to believe the information can be used to identify me.

I understand that once this protected health information is disclosed to the Recipient , he/she cannot guarantee that the Recipient will not redisclose my health information to a third party who may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my protected health information.

Please Note:

- You have a right to revoke this authorization in writing at any time and to send your written revocation to Clear Spring Health at the address listed below. Your revocation will not apply to information that Clear Spring Health has already disclosed in reliance on this Authorization.
- Information disclosed by Clear Spring Health in accordance with this request may be re-disclosed by the recipient and may no longer be protected by the HIPAA Privacy Regulations.

Signature:

I have read and understand the above information. I represent that the signature below is my own and that I am legally authorized to sign this document.

Member or Personal Representative* Signature

Print Name

Relationship, if signed by other than Member: _____

***** If not already provided, please attach legal documentation verifying personal representation. We will require verification of the authority of a Personal Representative before this request will be considered complete.

Please Return this Completed Form and Supporting Documentation *(if applicable)*

Email: membersupport@clearspringhealthcare.com

Fax: 1-866-643-6159

Or mail to: Clear Spring Health
PO Box 278470
Miramar, FL 33027

If you have any questions about this Authorization Form, please contact a Clear Spring Health Member Services Representative at: 1-877-317-6082 (TTY: 711). We are open from October 1 - March 31, seven days a week, 8:00 am – 8:00 pm and from April 1 – September 30, Monday through Friday, 8:00 am – 8:00 pm (you may leave a voicemail Saturday, Sunday and Federal Holidays.

***Note to recipients of substance use disorder information related to this authorization** (if applicable):*

This information has been disclosed to you from records protected by federal confidentiality rules (*42 CFR part 2*). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is *NOT* sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65.