Member Consent/HIPAA Authorization Form

your health care information as described below. All of this form must be filled out. Mail or fax it to the address listed at the end of this form. Or, you may fill out this form online at www.caresource.com.

Section 1: Exchanges (H

members. You also can share your health information			

the right to ask f

Check this box if you want your health information to be shared with the past, current, and future providers or your personal health care apps. The information will be shared for treatment, to manage your care, and to help with benefits. The information shared will include sensitive health information, including treatment for substance use and HIV/AIDs. For your personal health care apps, you will have more control over the information shared when you install it.

Or ±

• Check this box if you do not want your health information to be shared with past, current, and futureproviders . The information will not be shared for treatment, to manage your care, or to help with benefits. None of your health information will be shared with your providers, with these exceptions:

x Due to state requirements we must follow, your Primary 0 H G LH Provider (P 0P)