BayCare Plus
Medicare Advantage

HIPAA AUTHORIZATION FORM

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

A. **Member Name**_____ **ID#** _____

Authorizes and requests BayCare Health Plans to release information to:

B. **Recipient Name** _____

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, including free language translation services, please call our customer service at (866) 509-5396 from 8am to 8pm, seven days a week. TTY users should call 711 toll free. You may reach a messaging service on weekends from April 1 through September 30 and holidays. Please leave a message, and your call will be returned the next business day. You may also visit our website at BayCarePlus.org.

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 BayCare Health Plans 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 BayCare Health Plans 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)

BayCare Health Plans is an HMO plan with a Medicare contract. Enrollment in BayCare Health Plans 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 BayCare Health Plans member identified in Section A above, complete the following.

By signing this form, I represent that I am the legal representative of the BayCare Health Plans member identified in Section A and will provide BayCare Health Plans 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: **BayCare Health Plans**
PO Box 3710
Troy, MI 48007