MDwise
A McLaren Company

ACCREDITED NCQA HEALTH PLAN

Date: _____

Name: _____
Address: _____
City, State, Zip: _____
Member ID: _____
Member DOB: _____

Dear Member:

The Health Insurance Portability and Accountability Act of 1996 set up federal laws about sharing alcohol and other substance abuse records. It also created Indiana's laws relating to health and treatment records for alcohol, substance abuse and contagious disease(s). This letter permits the use and sharing of your Protected Health Information. The sharing of your health care records, including prescriptions and treatment advice, is vital for your care's safe and effective coordination.

Member Consent

By signing, I allow the information to be shared with other health care organization(s) by MDwise health care professionals in support of my health care. For example, I let the following information be shared.

- Health records: Including treatment, payment and health care operations.
- Communicable Disease Records.
- HIV/AIDS Records.
- Substance Abuse Records.
- Alcohol Abuse Records.

I understand that I may cancel this consent at any time by giving notice in writing to MDwise. This consent will expire upon ending my plan with MDwise. I can also remove this consent in writing before my plan expires. Under the law, the substance abuse records shared under this consent form may not be rereleased by MDwse. The recipient may share the other documents and may no longer be protected.

_____ _____

Signature of Member/Member's Designated Representative Date

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Consent to Speak to Another Person

If you are not the member, please also complete, sign, and date this section. Check the box that describes your relationship to the member. As discussed above, I give my consent for MDwise to speak to the following person(s) on my behalf about the matters and records, and to the extent, addressed above.

Print name of Personal Representative	Signature of Personal Representative	Date
Print name of Personal Representative	Signature of Personal Representative	Date

☐ Parent of Minor Child ☐ Legal Guardian* ☐ Power of Attorney* ☐ Executor* ☐ Other*

*If you are one of these persons you must provide proof of authority to act for the member and submit with this form.

Authorization for Release of Information to Other Health Care Organizations

As discussed above, I give my consent for MDwise to disclose the information and records, and to the extent, addressed above to the following health care organization(s).

[Name of Health Care Organization _____
Address of Health Care Organization] _____

[Name of Health Care Organization _____
Address of Health Care Organization] _____

P.O. Box 441423 • Indianapolis, IN 46244-1423
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