illinicare health™

Who can we talk to about your health?

Authorization to Disclose Health Information

Completing this form will allow IlliniCare Health to share your health information with the person or group that you identify below.

FILL IN ALL THE INFORMATION ON THIS FORM.
WHEN FINISHED, MAIL IT TO THE ADDRESS AT THE BOTTOM OF THE PAGE.

If you want all of your health information shared with the person/group named below please check the box below.

☐ **I give IlliniCare Health permission to share ALL of my health information with the person or group named below.**

If you only want some of your health information shared with the person/group named below, please check the boxes next to what you don't want shared.

☐ **I give IlliniCare Health permission to share all of health information EXCEPT:**
- ☐ Prescription drug/medication information
- ☐ Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) info
- ☐ Behavioral health services or psychiatric care information
- ☐ Other: _____ _____

Please fill in the information below on the person who is authorized to receive information on your health.

Name (person or group): _____
Address: _____
City: _____ Zip: _____
Phone: _____

Please provide an end date for this form. When should we stop sharing your health information with this person? Authorization End Date:_____

If you don't want us to speak to anybody about your health please check the box below.

☐ **I do not authorize IlliniCare to speak with any individual regarding my healthcare other than myself.**

Please fill in your information below.

Member info:

Member Name (print): _____
Date of Birth: _____ Member Medicaid ID #: _____

Member Signature:

_____ _____
(Member or Legal Representative Sign Here) Date

If you are signing for the member, describe your relationship below. If you are the member's personal representative, describe this below and send us copies of those forms (such as power of attorney or order of guardianship):

_____

MAIL TO:
IlliniCare Health
Privacy Officer
999 Oakmont Plaza Drive
Suite 400
Westmont, IL 60559
866-329-4701

Please see back of form for more details.

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How to cancel this form:

- Right to cancel (revoke): If you want to cancel this authorization form, fill out the revocation form online at www.illinicare.com or call us at 866-329-4701 to receive a copy of the form.

Additional information about this form:

- You do not have to sign this form or give permission to share your health information. Your services and benefits with IlliniCare Health will not change if you do not sign this form.
- IlliniCare Health cannot promise that the person or group you allow IlliniCare Health to share your health information with will not share it with someone else.
- Keep a copy of all completed forms that you send to us. IlliniCare Health can send you copies if you need them.