PLEASE READ THE INSTRUCTIONS CAREFULLY AND COMPLETE THE FORM BELOW. INCOMPLETE FORMS CANNOT BE ACCEPTED.

For assistance with this form please see Notice on page 2 or call Member Services for your plan.

HEALTH PLAN LOGO	HEALTH PLAN Name	MEMBER SERVICES
absolute total care. Healthy Connections	**Absolute Total Care (Medicaid)**	**1-866-433-6041 (TTY: 711)**

1 **MEMBER INFORMATION:**

Member Name *(print)*: ______________________________

Address: ______________________________

City:____________ State: ____________ Zip:__________ Phone: (______) _______ - ________

Member Date of Birth: ______________ Member ID Number:______________

2 **I GIVE ABSOLUTE TOTAL CARE PERMISSION TO USE MY HEALTH INFORMATION FOR THE PURPOSE IDENTIFIED OR TO SHARE MY HEALTH INFORMATION WITH THE PERSON OR GROUP NAMED BELOW.**

THE PURPOSE OF THE AUTHORIZATION IS *(check one option below)*:

□ to allow Absolute Total Care to help me with my benefits and services

OR

□ to permit Absolute Total Care to use or share my health information for______________

3 **PERSON OR GROUP TO RECEIVE INFORMATION:**

Name (person or group): ______________________________

Address: ______________________________

City:____________ State: ____________ Zip:__________ Phone: (______) _______ - ________

4 **I AUTHORIZE ABSOLUTE TOTAL CARE TO USE OR SHARE THE FOLLOWING HEALTH INFORMATION** *(NOTE: Select the first statement to release* ***ALL*** *health information or select the second statement to release only* ***SOME*** *health information.)*

Check only one box below. Both CANNOT be selected.

□ **All of my health information INCLUDING:**

Genetic information, services, or test results; HIV/AIDS data and records; mental health data and records (but not psychotherapy notes); prescription drug/medication data and records; and drug and alcohol data and records (please specify any substance use disorder information that may be disclosed).

OR

□ **All of my health information EXCEPT** *(check only the boxes below that apply)*:

- □ Genetic information, services, or tests
- □ AIDS or HIV data and records
- □ Drug and alcohol data and records
- □ Mental health data and records (but not psychotherapy notes)
- □ Prescription drug/medication data and records
- □ Other: ______________________________

5 **THIS AUTHORIZATION ENDS ON THIS DATE/EVENT:** ______________________________

Date this authorization ends unless cancelled. If this field is blank, the authorization expires one year from the date of the signature below.

6 **MEMBER OR LEGAL REPRESENTATIVE SIGNATURE:** ______________________________

DATE: ______________________

IF LEGAL REPRESENTATIVE - Relationship to Member: ______________________________

If you are the Member's legal or personal representative, you must send us copies of relevant forms, such as power of attorney or order of guardianship.

MAIL COMPLETED AUTHORIZATION FORM AND ANY SUPPORTING DOCUMENTATION TO

Absolute Total Care, ATTN: Compliance Department

100 Center Point Circle, Suite 100, Columbia, SC 29210

Authorization to Use and Disclose Health Information

Notice to Member:

- Fill in all the information on the form. When finished, mail the form and any supporting documentation to:

Absolute Total Care
ATTN: Compliance Department
100 Center Point Circle, Suite 100
Columbia, SC 29210

For assistance with this form please call Member Services for your plan listed below.

HEALTH PLAN LOGO	HEALTH PLAN Name	MEMBER SERVICES
absolute total care | Healthy Connections	**Absolute Total Care (Medicaid)**	**1-866-433-6041 (TTY: 711)**

- Completing this form will allow Absolute Total Care to (i) use your health information for a particular purpose, and/or (ii) share your health information with the individual or entity that you identify on this form.
- You do not have to give permission to use or share your health information. Your treatment, payment, enrollment, or eligibility for services with Absolute Total Care will not change if you do not submit this form. If you want to cancel this authorization form, send us a written request to revoke it at the address on the bottom of this page. A revocation form can be provided to you by calling Member Services for your plan at the number listed above or on the back of your member ID card.
- If you want to cancel this authorization form, except in situations where:(a) the Company has taken action in reliance thereon; (b) the authorization was obtained as a condition of obtaining insurance coverage and other law provides the insurer with the right to contest a claim under the policy or the policy itself, send us a written request to revoke it at the address on the bottom of this page. A revocation form can be provided to you by calling Member Services for your plan at the phone number listed above or on the back of your member ID card.
- Absolute Total Care cannot promise that the person or group you allow us to share your health information with will not share it with someone else and no longer be protected by 45 C.F.R. Part 164.
- If you are consenting to disclose any substance use disorder records to a recipient that is neither a third party payor nor a health care provider, facility, or program where you receive services from a treating provider, such as a health insurance exchange or a research institution (hereafter, "recipient entity"), you must specify the name of an individual with whom or the entity at which you receive services from a treating provider at that recipient entity, or simply state that your substance use disorder records may be disclosed to your current and future treating providers at that recipient entity.
- Keep a copy of all completed forms that you send to us. We can send you copies if you need them. You can request these by calling Member Services for your plan at the phone number which can be found above or on the back of your member ID card.
- If you need help, contact Member Services for your plan at the phone number listed above or on the back of your member ID card.