Authorization for Disclosure of Confidential Information

Important: It is important for your health information to be shared with all of your health care providers to ensure that you receive the best care possible. The purpose of sharing your health information with your providers or supports is to assist in identifying any follow-up medical care that may be needed.

Please allow Empower Healthcare Solutions, LLC and your treatment team to share your health information with each other by signing the release of information below, or having a person who is legally authorized to act on your behalf sign. We will only send and receive information that pertains to your care.

SECTION 1: WHOSE HEALTH CARE INFORMATION IS TO BE RELEASED?

I**,** _____**(Member Name)** authorize Empower (or any Empower subsidiary holding my information) to disclose my health care information as described below.

Additional Member Identifying Information: Member ID#: _____ DOB: ____/____/____

Phone Number: _____

SECTION 2: IDENTIFY THE PERSON, PROVIDER, OR ENTITY TO DISCLOSE THE INFORMATION

Arkansas Empower PASSE Name - Empower Healthcare Solutions, LLC Address – 1401 West Capitol Avenue, Suite 430 Little Rock, AR 72201 Phone – Toll Free - 866-261-1286 Fax – 888-614-5168	**Other (please specify** Name Address Phone Fax
Physical Health Plan/Medical Provider Name	**Other (please specify** Name
Address	Address
Phone	Phone
Fax	Fax
Substance Use Disorder Provider Name	**Other (please specify)** Name
Address	Address
Phone	Phone
Fax	Fax
Mental Health Provider Name	**Other (please specify)** Name
Address	Address
Phone	Phone
Fax _____	Fax _____

Is it ok to include information from past, present, and/or future treating provider(s)?: Yes No

SECTION 3: WHY SHOULD THIS HEALTH CARE INFORMATION BE RELEASED?

Reason ("At my request" is an acceptable response): _____

_____

Specify, if possible: Care Coordination/Management Claim Assistance Quality of Care Review

☐Other (Please explain reason): _____

(Initials: ___) Date:

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SECTION 4: WHAT HEALTH CARE INFORMATION MAY BE RELEASED?

Information to Which This Authorization Applies: 42 CFR regarding substance abuse confidentiality requires as limited information be disclosed as possible. **BY INITIALING** the following items, you are authorizing all those involved in my treatment to disclose the following specific types of information to the person(s) identified in Section 2 above:

Physical and Mental Health
(Initials: _____) All health information pertaining to any medical history, mental or physical condition, and treatment received (including services provided at a Community Mental Health Center and/or information related to HIV/AIDS status) in the possession, custody or control of the parties identified in this document, regardless of when such information was generated. This authorization does not include substance abuse records.

Substance Abuse
(Initials: _____) I specifically authorize the release of personal health information from my drug and alcohol assessment. The recipient of drug and/or alcohol abuse information disclosed as a result of this Authorization will need my further written authorization to re-disclose this information. 42 CFR §2.32 restricts any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.
Optional: Claims info Authorizations Explanation of benefit letters Denials/Appeals info Clinical notes

Specific Information
(Initials: _____) Other health information, please specify

SECTION 5: HOW LONG SHOULD THIS AUTHORIZATION LAST?

This authorization shall be in force and effect **for up to one year** or until I revoke it, in the manner described below or until **(insert expiration date or event**) _____ *(whichever is shorter)*.

SECTION 6: WHAT ARE MY RIGHTS?

Understand and Agree to the following:

- I have the right to review the information that is being disclosed;
- The recipient of this disclosed information does not have my permission to re-disclose it; however, I understand that this information may be at risk for re-disclosure by the recipient, and no longer protected by federal privacy laws;
- A provider cannot condition my treatment on whether I sign this authorization.
- You have a right to revoke this authorization at any time. ***But if you revoke this authorization, the revocation will not affect the disclosure of any information that Empower has already sent to the recipient***.
- This Release pertains only to information obtained by the coordinating agency, and does NOT include the member's chart, housed at the provider's office.
- If you authorized release of alcohol or substance use information to a healthcare organization that is not your treating provider, for the next two years, you have the right to find out who within that organization actually saw your information. You should contact the organization directly for that information.
- The coordinating agency will not receive compensation from a third party for using or disclosing this information, and
- I have the right to a copy of this form after I sign it.
  I would like a copy of this form: YES/NO Initials: _____

(Initials:) Date: _____

Authorization for Disclosure of Confidential Information

Signature of the Member or the Member's Legally Authorized Representative _____ Date _____

Print Name _____

Signature of the Individual and/or the Individual's Legally Authorized Representative** _____ Date _____

Relationship to the Individual/Member:

☐ Self ☐ Parent of Minor Child ☐ Legally Authorized Representative (*Legal Guardian)*** *Nature of relationship* _____

Witness Name _____ Date _____

Witness Agency: _____

** *Anyone over 14 years of age must sign this release for themselves, if substance abuse information is to be released. If mental health information is to be released and the individual is under 18 years of age, then the Legally Authorized Representative must also sign. If the Individual has been adjudicated and found to be incompetent in a court of law, the Legally Authorized Representative may sign this consent form on behalf of the Individual. Examples would be a health care power of attorney, a court order, guardianship papers, etc. A financial or business power of attorney is NOT sufficient. If you are signing as a Legally Authorized Representative attach a copy of the appropriate legal document(s) granting you the authority to do so. You do not have to attach copies of documents if you already have those documents on file with* Empower Healthcare Solutions, LLC. *My legal documents granting authority to act on the individual's behalf are already on file with* Empower Healthcare Solutions, LLC:

☐ *YES* *Initials:*

(Initials:) Date:_____