AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION AND TO HANDLE CARECENTRIX ACCOUNTS

I authorize CareCentrix, Inc. (CareCentrix) and its affiliates to release my protected health information (PHI) contained in the records maintained by CareCentrix or a CareCentrix affiliate as specified below to the individual or entity identified below.

Name and address of individual whose PHI is being disclosed:

IMPORTANT All fields with an asterisk must be completed.

*Name: _____

*Address: _____

* City:_____ * State: _____ * Zip Code: _____

*Date of Birth:_____/_____/_____ *Phone Number: (_____)_____-_____

*Insurer:_____*Insurer ID Number: _____

CareCentrix Account Number (####-#####):_____

Name and address of individual/entity to whom the PHI is to be disclosed (Authorized Person):

*Name: _____

*Address: _____

* City:_____ * State: _____ * Zip Code: _____

*Date of Birth:_____/_____/_____ *Phone Number: (_____)_____-_____

*Relationship to Patient: _____

I agree that my PHI may be disclosed to the Authorized Person through various means of communication, including but not limited to, by phone, email, fax and US mail. The purpose for the disclosure of PHI is to discuss my health care services and treatment plan and/or handle my accounts with CareCentrix, including but not limited to, my patient billing account. I further agree that the Authorized Person has full authority to handle my patient billing and other accounts with CareCentrix, including but not limited to, receiving copies of invoices and billing ledgers, making payments, receiving refunds of any overpayments, and making changes to my account information.

I understand that the above information to be disclosed under this authorization may contain information about HIV, AIDS diagnosis/treatment, mental health diagnosis/treatment, alcohol/drug diagnosis/treatment, developmental disability, and/or abuse, and I expressly authorize the disclosure of such information unless otherwise specifically indicated below:

Do not disclose any information about:
◯ HIV/AIDS diagnosis/treatment ◯ Alcohol/drug diagnosis/treatment
◯ Mental health diagnosis/treatment ◯ Developmental disability ◯ Abuse

I understand that I have a right to revoke this authorization at any time by contacting CareCentrix in writing, except to the extent information has been released in reliance upon this authorization. I also understand that the information released in response to this authorization may be re-disclosed to other parties and no longer protected by the federal Privacy Rule. I understand that my treatment, payment for treatment, or enrollment or eligibility for benefits with my insurer cannot be conditioned on the signing of this authorization. I understand that the information requested is the property of CareCentrix and that a reasonable fee may be charged for the copying of any such records. Any facsimile or photocopy of this authorization shall authorize CareCentrix and its affiliates to disclose the information requested herein. This authorization shall be effective as of the date of execution set forth below and remain in effect for a period of five years at which time this authorization expires.

*Signature:_____ *Date: _____

*Printed Name:_____

If signed by anyone other than the patient, relationship of authorized representative to individual:

_____

If authorized representative of the individual please attach corresponding authorization documentation (power of attorney, etc.).

Please mail completed form to (both pages must be included)

CareCentrix, Inc.
Attention: Mail Room
9119 Corporate Lake Drive, Suite 200
Tampa, FL 33634

Or Fax to:
Fax Number: (866) 536-8046

Or Email to:
authorizationtodisclosephirequest@carecentrix.com

Form Approved
OMB# 0938-1421

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-833-592-1093. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-833-592-1093. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-833-592-1093。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-833-592-1093。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-833-592-1093. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-833-592-1093. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-833-592-1093 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-833-592-1093. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-833-592-1093 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-833-592-1093. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-833-592-1093. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-833-592-1093 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-833-592-1093. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-833-592-1093. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-833-592-1093. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-833-592-1093. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-833-592-1093 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサービスです。