# Authorization to Disclose Health Information

**Notice to Member:**

- Completing this form will allow the plan to share your health information with the person or group that you choose.
- You do not have to sign this form or give permission to share your health information. Your services and benefits will not change if you do not sign this form.
- If you want to cancel this Authorization Form, fill out the Revocation Form on the next page. Mail it to us at the address below.
- Home State Health Plan can't promise that the person or group you choose will not share your information with someone else.
- Keep a copy of all forms that you send to us. The plan can send you copies if you need them.
- Fill in all information on this form. When finished, mail it to the address below.

**Member Information**:

Member Name (print): _____

Member Date of Birth: ___/_____/_____ Member Medicaid ID Number/Member ID#: _____

**I give permission to share my health information with the person or group named below. The purpose of the authorization is to help me with my benefits and services.**

**Recipient Information**:

Name (person/group): _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: (____) ____ - _____

**Home State Health Plan can share this Health Information: (check all boxes that apply)**

- ☐ All of my health information; OR
- ☐ All of my health information EXCEPT:
  - ☐ Prescription drug/medication information
  - ☐ AIDS or HIV information
  - ☐ Treatment for alcohol and/or substance abuse information
  - ☐ Behavioral health services or psychiatric care information
  - ☐ Other: _____

- **Authorization End Date**: _____/_____/_____ (If no date is provided, this authorization will expire in one year.)

**Member Signature**: _____ **Date**: ____/____/_____

(Member or Legal Representative Sign Here)

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

_____

**Home State Health Plan**
**Compliance Department**
16090 Swingley Ridge Road
Chesterfield, MO 63017

Fax: 1-866-390-4429; Member Services: 1-855-694-4663

# Revocation of Authorization to Disclose Health Information

I want to cancel the permission I gave to share my health information with this person or group:

**Recipient Information**:

Name (person/group): _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: (____) ____ - _____

Authorization Signed Date (if known): _____/_____/_____

**Member Information**:

Member Name (print): _____

Member Date of Birth: _____/_____/_____ Member Medicaid ID Number/Member ID#: _____

**I know that my health information may have already been shared because of the permission I gave before. I also know that this cancellation only applies to the permission I gave to share my health information with this person or group. It does not cancel any other authorization forms I signed for health information to be shared with another person or group.**

**Member Signature**: _____ **Date**: ____/____/_____

(Member or Legal Representative Sign Here)

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

_____

The plan will stop sharing your health information when we get this form. Use the mailing address below. You can also call for help at the number below.

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