Authorization to Use and Disclose Health Information

Notice to Member:

- Completing this form will allow Home State Health 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 sign this form or give permission to use or share your health information. Your services and benefits with Home State Health will not change if you do not sign this form.
- If you want to cancel this authorization form, send us a written request to revoke it to the address at the top of the second page. A revocation form can be provided to you by calling Member Services.
- Home State Health cannot promise that the person or group you allow us 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. We can send you copies if you need them.
- Fill in **all** the information on this form. When finished, mail it to the address at the top of the second page.

MEMBER INFORMATION:

Member Name (print): ______________________________

Member Date of Birth: ____________________ Member ID Number: ____________________

I give Home State Health 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:

☐ to allow Home State Health to help me with my benefits and services, or

☐ to permit Home State Health to use or share my health information for ____________________

PERSON OR GROUP TO RECEIVE INFORMATION (add additional Persons or Groups on page 2):

Name (person or group): ______________________________

Address: ______________________________

City: ____________ State: ____________ Zip: ________ Phone: (_____) _____ - ______

I AUTHORIZE HOME STATE HEALTH TO USE OR SHARE THE FOLLOWING HEALTH INFORMATION:

☐ **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 all boxes 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: ______________________________

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

Member Signature: ______________________________ **Date:** _____ / _____ / _________

(Member or Legal Representative Sign Here)

Relationship to Member: ______________________________

If you are the Member's personal representative, please send us copies of those forms (such as power of attorney or order of guardianship).

Mail to: *Home State Health Compliance Department*
11720 Borman Drive
St. Louis, MO 63146
Member Services: 1-855-694-4663; Fax: 1-866-390-4429

ADDITIONAL INDIVIDUAL PERSON(S) OR ENTITY(IES) TO RECEIVE INFORMATION

NOTE: 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.

Name (individual or entity): ______________________________

Address: ______________________________

City: ____________ *State:* ____________ *Zip:* ____________ *Phone: (   )   -* ____________

Name (individual or entity): ______________________________

Address: ______________________________

City: ____________ *State:* ____________ *Zip:* ____________ *Phone: (   )   -* ____________

Name (individual or entity): ______________________________

Address: ______________________________

City: ____________ *State:* ____________ *Zip:* ____________ *Phone: (   )   -* ____________

Name (individual or entity): ______________________________

Address: ______________________________

City: ____________ *State:* ____________ *Zip:* ____________ *Phone: (   )   -* ____________

Name (individual or entity): ______________________________

Address: ______________________________

City: ____________ *State:* ____________ *Zip:* ____________ *Phone: (   )   -* ____________

Name (individual or entity): ______________________________

Address: ______________________________

City: ____________ *State:* ____________ *Zip:* ____________ *Phone: (   )   -* ____________

Name (individual or entity): ______________________________

Address: ______________________________

City: ____________ *State:* ____________ *Zip:* ____________ *Phone: (   )   -* ____________

English:

If you, or someone you're helping, has questions about Home State Health, you have the right to get help and information in your language at no cost. American Sign Language interpreter services are available as well. To talk to an interpreter, call 1-855694-4663 (TTY/TDD 1-877-250-6113).

Español (Spanish):

Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Home State Health, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-855-694-4663 (TTY/TDD 1-877-250-6113).

中文 **(Chinese):**

如果您，或是您正在協助的對象，有關於 Home State Health 方面的問題，您有權利免費以您的母語得到幫助和訊息。還提供美國手語口譯服務。如果要與一位翻譯員講話，請撥電話 1-855-694-4663 (TTY/TDD 1877-250-6113)。

Non-Discrimination Notice:

English:

Home State Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Español (Spanish):

Home State Health cumple con las leyes Federales de derechos civiles correspondientes y no discrimina con base en la raza, el color, la nacionalidad, la edad, la discapacidad o el sexo.

Chinese:

Home State Health 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。