



AUTHORIZED REPRESENTATIVE FORM

Note: This form is used to confirm a Member's permission that the Health Plan[†] may discuss or disclose Protected Health Information (PHI) to a particular person who acts as the Member's Authorized Representative. Use of the PHI is strictly limited to that purpose.

Section A: Member Information

By signing this form in Section E below, I understand and agree that the Health Plan may release my PHI as defined in Section B below to my Authorized Representative(s) named in Section C below.

Print Name of Member: _____ Date of Birth (mm/dd/yy): _____

Address: _____

Telephone Number: _____ Member Identification Number: _____

Please note: this authorization does not provide your "Authorized Representative" with any authority, either implied or direct, over any treatment or direct care decisions. If you wish to designate a health care partner/proxy or a clinical personal health care representative, or if you would like to establish a living will or health care power of attorney, please discuss this with your attorney, your doctor or call the toll-free phone number on your membership card and a member services associate will assist you. Also, the Health Plan will not condition benefits payments, enrollment, or eligibility for benefits on the execution of this form.

Section B: Scope of Information

Information Authorized for Use or Disclosure:

- PHI includes, but is not limited to, premium information, eligibility status, claims history, identification of treating providers of care, diagnoses, procedures, and demographic information.
- This information may include diagnoses and/or treatment for alcohol and/or drug abuse; AIDS/AIDS Related Complex (ARC) and HIV diagnoses and/or treatment; and diagnoses and/or treatment relating to other communicable diseases.
- This authorization does not cover disclosure of psychotherapy notes.

Section C: Authorized Use and/or Disclosure

Intended Use or Disclosure:

I understand that the Health Plan's general policy is not to disclose my personal health information to other parties, except those directly involved in my care, without my written authorization or as permitted or required by law. For this reason, I authorize you to discuss and disclose my PHI to the person(s) named below for the purpose of assisting with, or facilitating, the coordination or payment of my health plan benefits. I also understand that if my Authorized Representative is not a health care provider or another entity subject to federal or applicable state privacy laws, those privacy laws may no longer protect my PHI and my Authorized Representative (if applicable) may further disclose my PHI without my authorization. I acknowledge that my authorization is voluntary.

Authorized Representative #1:

Print Name: _____ Date of Birth (mm/dd/yy): _____

Address: _____

Relationship to You: _____ Telephone Number: _____

[†] The Health Plan is owned by WellCare Health Plans, Inc., a member of The WellCare Group of Companies, which includes: WellCare of Florida, Inc., HealthEase of Florida, Inc., WellCare of New York, Inc., WellCare of Connecticut, Inc., The WellCare Management Group, Inc., WellCare of Louisiana, Inc., WellCare Behavioral Health, Inc., Comprehensive Health Management, Inc., Comprehensive Health Management of Florida, L.C., Harmony Health Systems, Inc., Harmony Health Plan of Illinois, Inc., Harmony Health Management, Inc., WellCare of Georgia, Inc., WellCare Prescription Insurance, Inc., and WellCare Health Insurance of Arizona, Inc.

