Member Consent for Release of Protected Health Information

Wellmark Advantage Health Plan

Wellmark Advantage Health Plan, Inc. is an independent licensee of the Blue Cross and Blue Shield Association.

Use this form to allow Wellmark Advantage Health Plan to share your protected health information (also known as PHI) with an individual or organization.

A Member who is giving consent

This form can only be used for one member. Please submit a separate form for each member.

Name _____ **Date of birth** _____

Enrollee ID (number on ID card beginning with 1 to 3 letters) _____

Address _____ **Daytime phone** _____

City _____ **State** _____ **ZIP** _____

B Protected health information to be shared *(check one)*

- ☐ Any and all information (including personal, health, demographic, claims, billing and medical records)
- ☐ Only limited information (such as for specific treatments, dates of service or billing details)

(please describe) _____

Please check below if you would also like to include any of the following highly protected information (known as Super PHI):

- ☐ Substance use records (including alcoholism)
- ☐ AIDS or HIV treatment records
- ☐ Mental health services (does not include psychotherapy notes)

C Person or organization that may receive your information

Note: If information is shared with a person or organization that is not legally required to obey privacy laws, the information may be shared with others and no longer protected.

Print first and last name for a person, and the most detailed name possible for an organization (for example, hospital name and department).

Recipient's full name _____

Please check the box below describing the person or organization's relationship to you.

- ☐ Family member
- ☐ Friend
- ☐ Doctor or health care provider
- ☐ Other *(describe)* _____

Form continues on page 2.

D Expiration and cancellation

This permission will expire *(check one box only)*:

☐ On this date (month, day and year, MM/DD/YYYY)

_____

☐ When canceled, or upon my death

I understand that I can cancel this authorization at any time by submitting a written request on a standard form, available online at **www.WellmarkAdvantageHealthPlan.com** or by calling the number listed on the back of my ID card. I understand that cancellation will not apply to information that has been released by this authorization.

E Authorization and signature

I allow the use and disclosure of my protected health information as described above. This information is being released at my request. I understand that my treatment, payment, enrollment or eligibility for benefits does not depend on whether I sign this authorization.

Signature of member

SIGN HERE _____

Date: _____

IMPORTANT: Please read the form over carefully and be sure you have included all necessary information. We cannot take additional information by phone, fax or email. If information is missing, we will have to contact you and request a new form.

Mail completed consent form to:

Wellmark Advantage Member Correspondence

PO Box 260040
Plano, TX 75026

or fax to: **1-800-456-9517.**

For additional assistance completing this form, call the number listed on the back of the member's ID card.