CHRISTUS Health Plan

Consent for Disclosure of Confidential Information

I hereby authorize CHRISTUS Health Plan and any of its parents, subsidiaries, or other affiliates and their respective agents and subcontractors, to disclose confidential information about the member/insured listed below.

I UNDERSTAND THIS AUTHORIZATION IS VOLUNTARY and the information to be disclosed may be protected by law.

Member Full Name (Print) _____ Member ID Number _____ Date of Birth (MM/DD/YYYY) _____

Street Address _____ City/State/ZIP Code _____ Daytime Phone Number _____

Check one or more boxes to select the specific personal health information to be disclosed.

☐ Any and all protected health information CHRISTUS Health Plan and its affiliates maintain, including diagnosis and treatment information, information on chronic diseases, behavioral health conditions, including alcohol or substance abuse, communicable diseases, including HIV/AIDS and/or genetic marker information. Health programs, plan information, and caregiver resources may also be disclosed.

☐ Protected health information about treatment for the following condition or injury, or other information (include dates): _____

_____

_____

_____

I authorize the individual(s) or organization(s) identified below to receive the selected confidential information pertaining to the member/insured named above.

Individual(s) or organization(s) authorized to receive confidential information _____

Street Address _____

City/State/ZIP Code _____

Daytime Area Code and Phone Number _____

Information to be disclosed to this individual or organization includes application or enrollment information, eligibility information, claims records, claim status, and patient management records.

IMPORTANT: ***Your signature below means you understand and agree to the following:***

- You understand your eligibility for benefits and payment for services covered by CHRISTUS Health Plan under your plan will not be affected if you do not sign this form. (However, without your signature, your request to release the information described above to a third party will not be honored.)
- You understand you may receive a copy of this form if you ask for it by writing to the address listed at the bottom of this page.
- You understand this authorization will expire one year from the date you sign this authorization. You also understand if you sign this form, you may revoke the authorization at any time by notifying CHRISTUS Health Plan in writing, but if you do, it will not have any effect on actions CHRISTUS Health Plan took before we received the notification.
- You agree to hold CHRISTUS Health Plan and its affiliates harmless from any claim or liability, including, but not limited to, any claim brought under a confidentiality or privacy law, in connection with the release at your request of information and records described above.
- You understand that your personal health information may be re-disclosed by the person(s) or organization(s) named on this form and may no longer be protected by law.

Signature of member or legal representative Date

Print name of member legal representative (if applicable) Relationship to member/insured

If this authorization is being requested by member/insured's legal representative, you must furnish a copy of the power of attorney, or other relevant document designating you as the representative.

Send your completed, signed authorization to:

CHRISTUS Health Plan
ATTN: Care Management
5101 N. O'Connor Blvd
Irving, TX 75039