Release to Use and Share Health Information

NOTICE TO MEMBER

- This notice shares how your health information may be used or shared and how you can get this information. Please read it carefully.
- Filling out this form will allow Iowa Total Care to:
    - use your health information for a certain purpose, and/or group, **and/or**
    - get from or share your health information with a certain person or group that you state on this form.
- You do not have to sign this form or allow us to use or share your health information. Your services and benefits with Iowa Total Care will not change if you do not sign this form.
- To cancel this release form, you can:
    - Send us a written request. Mail it to the address at the bottom of page 2.
    - Call Member Services at 1-833-404-1061 (TTY: 711).
    - Visit IowaTotalCare.com > For Member > Member Handbook, Manuals & Forms > Revocation of Authorization to Disclose Health Information (PDF).
- When choosing to share your health information with someone else Iowa Total Care cannot guarantee that they won't share it with others.
- Keep a copy of all finished forms that you send to us. We can also send you copies if you need them.
- If you need help, call Member Services at the phone number on the back of your member ID card.
- Fill in all the information on this form. Send the completed form and any supporting documents by mail or fax to:

Iowa Total Care
Attn: ROI Processing Team
1080 Jordan Creek Parkway, Suite 400S
West Des Moines, IA 50266
Fax: 1-833-847-3026

Autorización para usar y compartir información de salud

AVISO PARA EL AFILIADO

- Este aviso indica cómo se puede usar o compartir su información de salud y cómo usted puede obtener dicha información. Léalo atentamente.
- Llenar este formulario le permitirá a Iowa Total Care:
    - usar su información de salud para un propósito o un grupo determinados **y/o**
    - obtener información sobre su salud o compartirla con una determinada persona o grupo que usted indique en este formulario.
- No tiene que firmar este formulario no otorgarnos permiso para usar o compartir su información de salud. Sus servicios y beneficios con Iowa Total Care no cambiarán si no firma este formulario.
- Para cancelar este formulario de autorización, puede hacer lo siguiente:

- Enviarnos una solicitud por escrito. Envíela por correo a la dirección que figura en la parte inferior de la página 2.
- Llamar a Servicios para Miembros al 1-833-404-1061 (TTY: 711).
- Visitar IowaTotalCare.com For Member (para miembros) > Member Handbook, Manuals & Forms (Guía, manual y formularios para miembros > Revocation of Authorization to Disclose Health Information (Revocación de la autorización para divulgar información de salud) (PDF).

- Si decide compartir su información médica con otra persona, Iowa Total Care no puede garantizar que esa persona no la comparta con otros.
- Guarde una copia de todos los formularios rellenados que nos envíe. También podemos enviarle copias si las necesita.
- Si necesita ayuda, llame a Servicios para afiliados al número de teléfono que figura en el reverso de su tarjeta de identificación de afiliado.
- Complete toda la información en este formulario. Envíe el formulario completado y los documentos de respaldo por correo o fax a:

Iowa Total Care
Attn: ROI Processing Team
1080 Jordan Creek Parkway, Suite 400S
West Des Moines, IA 50266
Fax: 1-833-847-3026

PLEASE COMPLETE THE FORM BELOW. PLEASE PRINT.

1 **MEMBER INFORMATION:**

Member Name (*Required*):_____

Member Date of Birth:_____ Member ID Number: _____

2 **I ALLOW IOWA TOTAL CARE TO USE MY HEALTH INFORMATION FOR THE REASON STATED OR TO BOTH OBTAIN FROM OR SHARE MY HEALTH INFORMATION WITH THE PERSON OR GROUP NAMED BELOW.** (*Required*)

The purpose of the release is *(check all boxes that apply):*

☐ to allow Iowa Total Care to help me with my benefits and services.
AND/OR
To allow Iowa Total Care to use or share my health information for:

☐ Treatment/Care Coordination
☐ Billing/Claims
☐ Health Records/Documents
☐ Enrollment/Eligibility
☐ Other: _____

3 **PERSON OR GROUP TO BOTH OBTAIN FROM OR SHARE MY INFORMATION (*Add extra Persons or Groups on page 2*):**

Person or Group Name (*Required*):_____
Address:_____
City:_____State:_____Zip:_____Phone:(_____) _____

4 **I ALLOW IOWA TOTAL CARE TO USE OR SHARE THE FOLLOWING HEALTH INFORMATION** (NOTE: Choose the first option to share ALL health information or choose the second option to share only **some** health information. **Both CANNOT be chosen.**) (*Required*)

☐ **All of my health information:**
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
- ☐ Medication data and records
- ☐ Other: _____

5 **Release End Date** (*Required*)**:**_____/_____/_____
(*date the release ends or five years, whichever is sooner, unless cancelled)*

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6 Member Signature (*Required*):_____

(Member or Legal Representative sign here)

Date (*Required*): _____/_____/_____

Relationship to the Member: _____

(Signers, if you are not the Member, identify your relationship to the Member, i.e., Guardian, Parent, Spouse, etc.)

If you are the Member's personal representative, please mail or fax copies of those forms (such as power of attorney or order of guardianship) to:

Iowa Total Care | Attn: ROI Processing Team
1080 Jordan Creek Parkway, Suite 400S | West Des Moines, IA 50266 | Fax: 1-833-847-3026

ADDITIONAL INDIVIDUAL PERSON(S) OR GROUP(S) TO GET OR SHARE INFORMATION

Name (Person or Group): _____
Address: _____
City: _____ State: _____ Zip: _____ Phone: (__) _____

Name (Person or Group): _____
Address: _____
City: _____ State: _____ Zip: _____ Phone: (__) _____

Name (Person or Group): _____
Address: _____
City: _____ State: _____ Zip: _____ Phone: (__) _____

Name (Person or Group): _____
Address: _____
City: _____ State: _____ Zip: _____ Phone: (____)_____

Name (Person or Group): _____
Address: _____
City: _____ State: _____ Zip: _____ Phone: (____)_____

Name (Person or Group): _____
Address: _____
City: _____ State: _____ Zip: _____ Phone: (____)_____

Name (Person or Group): _____
Address: _____
City: _____ State: _____ Zip: _____ Phone: (____)_____

Name (Person or Group): _____
Address: _____
City: _____ State: _____ Zip: _____ Phone: (____)_____

Return completed form by mail or fax:

Iowa Total Care
Attn: ROI Processing Team
1080 Jordan Creek Parkway, Suite 400S
West Des Moines, IA 50266
Fax: 1-833-847-3026

Iowa Total Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. | Iowa Total Care cumple con las leyes federales de derechos civiles aplicables y no discrimina en base a la raza, el color, el país de origen, la edad, la discapacidad o el sexo.

Language assistance services, auxiliary aids and services, larger font, oral translation, and other alternative formats are available to you at no cost. To obtain this, please call 1-833-404-1061 (TTY: 711). | Usted tiene a su disposición, sin costo alguno, servicios de asistencia lingüística, ayudas y servicios auxiliares, material en letra grande, traducción oral y otros formatos alternativos. Para obtener estos servicios, llame al 1-833-404-1061 (TTY: 711). | 我们免费为您提供语言协助服务、辅助设施和服务、更大字体、口头翻译和其他替代格式。如需获得此服务，请致电 1-833-404-1061 (TTY: 711) 。