Instructions for Completion of Healthmap's HIPAA Authorization

This document is intended to assist members and their caregivers in completing Healthmap's HIPAA Authorization form. By completing and signing the form, members authorize Healthmap to speak to their Recipient about the member's protected health information ("PHI"). See below for a guide to assist with completion of the form.

- Identification of Member: The member should print their full name, date of birth, and address.

- Identification of Recipient: The member should print the full name, telephone number, and address of the member's Recipient. The Recipient is an individual to whom Healthmap may discuss or disclose the member's protected health information. The member may **NOT** list him or herself as the Recipient.

- Covered Disclosures: The member should specify whether the HIPAA Authorization permits Healthmap to speak to the Recipient(s) regarding:
    1. All of the member's past, present, and future healthcare matters;
    2. Solely healthcare matters limited to a specified period of time; or
    3. Solely specific medical condition(s) of the member.

- Exclusion of Sensitive Data: Members can indicate whether the authorization for Healthmap to speak to the member's caregiver excludes certain sensitive conditions (e.g., abuse, substance use disorder, HIV/AIDS, etc.).

- Expiration Date: The member must provide an expiration date for the authorization, which should be written as a date in the future or death.

- Signature: Either the member or a legally authorized representative of the member must sign the form.

    1. If the member is capable, the member must sign the form in the first signature block labeled "Signature of Member."
    2. If the member is incapable of providing their signature, the member can sign the form with an "X" or similar mark in the signature block labeled "Signature or Mark of the Member." Someone who witnessed the member make the mark must sign next to the member's mark as a witness.
    3. If an individual has legal authority to act on behalf of the member, that individual may execute this document on behalf of the member in the signature block labeled "Signature of Individual with Legal Authority." The document authorizing legal authority (e.g., power of attorney) must be submitted with this form.

Please return a copy of the attached HIPAA Authorization form to care.coordination@healthmapsolutions.com. If you have any questions related to this HIPAA Authorization form please contact Healthmap's Compliance Department at (800) 441-4259 and compliance@healthmapsolutions.com.

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
Required by the Health Insurance Portability and Accountability Act of 1996
(HIPAA) Privacy Standards

Print Name of Member: _____

Date of Birth: _____ Address: _____

I, the member, or the member's authorized representative, authorize **HEALTHMAP SOLUTIONS** to use and/or disclose the protected health information described below to (the "Recipient"):

_____

Printed Name *Phone Number*

_____

Address *City* *State* *Zip Code*

The authorization covers uses and disclosures of the following health information: (check one)

- ☐ All past, present, and future periods, **OR**
- ☐ For the period of health care from _____ to _____, **OR**
- ☐ My health information relating to the following treatment or condition: _____

Additional Consent for Certain Conditions

This medical record may contain information **about physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment. Separate consent must be given before this information can be released.**

- ☐ I consent to have the following information released:
  - ☐ Physical or sexual abuse
  - ☐ Alcoholism, drug, and substance
  - ☐ Sexually transmitted diseases
  - ☐ Abortion
  - ☐ Mental health treatment
  - ☐ Genetic information, including genetic test results
- ☐ I do not consent to have information released regarding these certain conditions.

Additional Consent for HIV/AIDS

This medical record may contain information concerning **HIV testing and/or AIDS diagnosis or treatment**. Separate consent must be given to have this information released.

☐ I consent to have the above information released.

☐ I do not consent to have the above information released.

This medical information may be used by the Recipient for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

1. This authorization shall be in force and effect until _____, at which time this authorization expires.
   Date authorization will expire
   OR life event such as death.

2. I understand that I have the right to revoke this authorization, in writing, at any time by emailing compliance@healthmapsolutions.com. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

3. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

4. I understand that information used or disclosed pursuant to this authorization may be disclosed by the Recipient and may no longer be protected by federal or state law.

5. I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

For California and Texas Members ONLY:
If the member resides in California or Texas, or treatment was rendered in California or Texas, please complete the following section. The release shall be limited to the following types of information:

- ☐ **Entire record, no limitation**
- ☐ Provider's orders
- ☐ Progress notes
- ☐ History/Physical exam
- ☐ Member allergies
- ☐ Diagnosis
- ☐ Past/Present medications
- ☐ Social history
- ☐ Individual treatment plan
- ☐ Legal information
- ☐ Medical assessments (e.g., EKG)
- ☐ Lab and test results
- ☐ Billing information
- ☐ Other (please specify): _____

SIGNATURE AUTHORIZATION for Texas members: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE

_____	_____	_____
Signature of Member (The person about whom the information relates)	**Print Member's Name**	**Date**

OR

If this form is being completed by a **person without legal authority to act on the member's behalf** because the member is illiterate or incapacitated, please complete the following information:

_____	_____	_____
Signature or Mark on Behalf of Member	**Print Name of Individual Acting on Member's Behalf**	**Date**

OR

If this form is being completed by a **person with legal authority to act on the member's behalf**, such as a parent or legal guardian, a health care agent, or an individual acting pursuant to a power of attorney or court order, please complete the following information:

_____	_____	_____
Signature of Individual with Legal Authority	**Print Name of Individual with Legal Authority**	**Date**

Please describe this person's legal authority to sign on behalf of the member:

_____

If you believe that Healthmap Solutions Inc. has failed to protect your protected health information or you have a question or concern you would like Healthmap to address, please notify the Privacy Officer by writing to the Privacy Officer at Healthmap Solutions Inc., 4631 Woodland Corporate Blvd, Suite 201, Tampa, FL 33614, or via email at compliance@healthmapsolutions.com and/or call 1-877-546-7004 or if you use a TTY, call 711.