Date:

Name
Address
City, State, Zip
Member ID:
Member DOB:

Dear Member:

In accordance with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), including but not limited to, 45 C.F.R. § 164.508; federal laws regarding the disclosure of alcohol and other substance abuse records, 42 C.F.R § 2, et seq.; and the State of Indiana's records laws pertaining to health records, and records relating to treatment for alcohol, substance abuse, and/or communicable disease(s), this letter serves to obtain authorization to use and/or disclose information about your Protected Health Information (PHI). The sharing of your health care information, including prescriptions and treatment recommendations, is essential for safe and effective coordination of your care.

Member Consent

By signing below, I authorize the following information to be shared with the individual(s) and/or health care organization(s) identified below in furtherance of my health care, and as determined by MDwise health care professionals and other MDwise employees. I further authorize that the information below may be disclosed to the extent needed to carry out and complete the purpose of the disclosure.

- Health records, including records relating to treatment, payment, and/or health care operations
- Communicable Disease Records
- HIV/AIDS Records
- Substance Abuse Records
- Alcohol Abuse Records

I understand that I may revoke this authorization at any time by giving written notice to the organization that is authorized above to release information. This authorization will expire upon my termination from the MDwise plan in which I am enrolled, unless I revoke this authorization in writing prior to the termination date. Pursuant to applicable law, the substance abuse records disclosed under this authorization may not be re-disclosed. Other records disclosed under this authorization however, may be re-disclosed by the recipient and may no longer be protected.

_____ _____

Signature of Member/Member's Designated Representative Date

Consent to Speak to Another Person

As discussed above, I give my consent for MDwise to speak to the following person(s) on my behalf about the matters and records, and to the extent, addressed above.

_____	_____
Name	Relationship
_____	_____
Name	Relationship

Authorization for Release of Information to Other Health Care Organizations

As discussed above, I give my consent for MDwise to disclose the information and records, and to the extent, addressed above to the following health care organization(s).

[Name of Health Care Organization
Address of Health Care Organization]

[Name of Health Care Organization
Address of Health Care Organization]

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