



HIPAA AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

(Protected Health Information includes an individual's health information that relates to their past, present or future physical or mental health and provision and payment of health care to an individual.)

I give permission for any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility or other healthcare provider that has provided payment, treatment or services to me or on my behalf and/or their business associates to give out **protected health information (PHI)** pertaining to me or any of my dependents listed below. The information that may be requested by Care Advocates for the purpose of assisting me with questions, obtaining health care services and approval or payment for health care services includes enrollment, claims payment, medical records and/or managed care information.

Employer Name (required):		
Member Name (required):		
Social Security #:		
Date of Birth:		
Telephone #:		
Address:		
Name of Health Insurance Carrier:		
Phone #:	Policy #:	Group #:
Dependents to Whom This May Apply		
Name:	Date of Birth:	Relation to Member:
Name:	Date of Birth:	Relation to Member:
Name:	Date of Birth:	Relation to Member:
Name:	Date of Birth:	Relation to Member:

Check if authorization includes information on mental health or substance abuse.

1. I understand that the information disclosed based on this authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal privacy regulations.
2. I understand that Care Advocates provides information and administrative services and does not provide or replace health insurance coverage, provide medical care or recommend treatment.
3. I understand that I may revoke or withdraw this authorization at any time by sending a written notice to:

Care Advocates
 P. O. Box 998
 Covington, LA 70434

 and it will be effective for future uses and disclosures of the information described above. It will not have any effect on information already used or given out.
4. This authorization expires (it is required you identify a specific date or event): _____

Signature of Individual or Individual's Representative (required)

Date (required)

Print name of the Individual's Representative and Relationship
(If the patient has designated an Authorized Representative, their signature is required)

Authority to act on behalf of Individual

Submission Instructions

Submit Online: Complete this form and print out. Then sign, scan and upload via our secure website at www.careadvocates.com/forms. Fax: to Care Advocates/FORMS at 985-898-1707. Mail completed authorizations to Care Advocates, ATTN: FORMS, P.O. Box 998, Covington, LA 70434. Members who need additional assistance completing this form should call Care Advocates at: 1-866-891-3306.