Authorization to Disclose Health Information

Notice to Member:

Completing this form will allow Ambetter from Arkansas Health & Wellness to share your health information with the person or group that you choose.

- You do not have to sign this form or give permission to share your health information. Your services and benefits will not change if you do not sign this form.
- Right to cancel (revoke): If you want to cancel this Authorization Form, fill out the Revocation Form and mail it to us at the address at the bottom of the page.
- Ambetter from Arkansas Health & Wellness can't promise that the person or group you choose will not share your information with someone else
- Keep a copy of all forms that you send to us. Ambetter from Arkansas Health & Wellness can send you copies if you need them.
- All information on this form must be completed. When finished, mail it to: Ambetter from Arkansas Health & Wellness Compliance Department

Member Information:

Member Name (print): _____

Member Date of Birth: ___/___/___ Ambetter ID #: _____

I give permission to share my health information with the person or group named below. The purpose of the authorization is to help me with my benefits and services.

Recipient Information:

Name (person/group):

_____

Address:

_____

City: _____ State: _____ Zip: _____ Phone: (___) ____ - _____

Ambetter from Arkansas Health & Wellness can share the following health information:

(Check all boxes that apply)

- ☐ All of my health information
- ☐ Billing information
- ☐ All of my health information EXCEPT:
  - ☐ Prescription drug/medication information
  - ☐ AIDS or HIV information
  - ☐ Behavioral health services or psychiatric care information
  - ☐ Other:_____

Authorization will end 1 year from date signed, unless revoked, or alternate expiration date is expressed below, but in no event to exceed 24 months from date of signature.

Alternate expiration date: ____/____/_____

Member Signature: _____ **Date:** ___/___/____
(Member or Legal Representative Sign Here)

If you are signing for the Member, describe your relationship below. If you are the Member's legal representative, describe this below. You must also send legal documents proving you are the member's legal representative (such as power of attorney or order of guardianship).

_____

_____

If you have questions, need help to understand this form or need a different language or format, please contact:

Member Services: 1-877-617-0390
Fax: 1-877-617-0393

Mailing Address:
Ambetter from Arkansas Health & Wellness
PO Box 25538
Little Rock, AR 72221

Note: This form is not acceptable for alcohol and/or substance abuse please contact Member Services at 1-877-617-0390 if you need more information on this.