Authorization for Disclosure of Contact Information

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with federal law concerning the privacy of such information.

Disclosure Authorization

By signing this Authorization for Disclosure of Heath Information, I authorize the nursing home identified below to disclose my name, address, and telephone number, or, the contact information for my personal representatives/responsible parties to a health care plan so that health care plan(s) contracted with the nursing home identified below may contact me about their products and services.

Nursing Home Name | Nursing Home Telephone No.

Nursing Home Address | City | State | Zip Code

I understand the following:

- **My permission to disclose my contact information or my personal representative's contact information will expire one year from the date indicated below unless the nursing home identified above receives earlier written notification from me ending my permission to give my information to other parties. However, this will not effect any actions that have already occurred due to my original permission.**
- **I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and sent to the nursing home identified above. My revocation will be effective upon receipt, but will not be effective to the extent that others have acted in reliance upon this authorization**
- **My personal health information will be used only for the purposes outlined above.**
- **This authorization is voluntary. I may refuse to sign this form. I understand that my provider(s) may <u>not</u> condition treatment, payment, enrollment, or eligibility for benefits based on my refusal to sign this authorization**
- **If my information is re-disclosed to a third-party who is not a health care provider or health care plan, or health care clearinghouse, it may not be protected by federal privacy laws.**
- **No other personal health care information will be released to any third-part pursuant to this authorization**

Print Name of Applicant/Member/Authorized Representative | Medicare ID Number

Signature of Applicant/Member/Authorized Representative | Date

Email Address

If you are the authorized representative of the applicant, you must provide the following information:

Relationship to Applicant | Address | Telephone No.

**CommuniCare Advantage is the DBA for the legal entity OH CHS SNP, Inc.*