AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Please print all information ***Submit completed form to:*** conciergecare@wellaway.com

I hereby authorize the use and/or disclosure of the below named individual's health information as described herein:

SECTION A. AUTHORIZATION

I authorize WellAway Limited to make disclosure of my protected health information in the manner described herein.

SECTION B. MEMBER INFORMATION *(individual whose information will be released)*

Name *(First, Middle, Last, Title)*:	
Group number *(if applicable)*:	**Member ID number:**
Address *(including zip code)*:	
Telephone Number *(including area code)*:	**Date of birth** *(mm/dd/yyyy)*:

SECTION C. RECIPIENT *(person or organization that will receive your information)*

Name of Person/Organization:	
Address *(including zip code)*:	
Email address:	
Telephone Number *(including area code)*:	**Fax Number** *(if available)*:

SECTION D. DESCRIPTION OF THE INFORMATION TO BE RELEASED *(what type of information you are authorizing to be used/disclosed)*

Check ONLY ONE box:

☐ **Behavioral Health Services –** If this form authorizes the use/disclosure of mental health and/or substance use disorder records, it may not be used to authorize the use/disclosure of any other health information. A separate authorization is required for any other use/disclosure.

☐ **All information related to the provision of and payment for my health care benefits or services.**

☐ **Approximate date(s) of treatment or event/claim related to specific treatment or service.**

Approximate date *(mm/dd/yyyy)*:	**Approximate date** *(mm/dd/yyyy)*:

Note: *State law requires that you give specific permission to release the information below even if you checked a box above. Indicate your permission for WellAway Limited to release any of the following information by initialing all that apply.*

Genetic information *(initials)*	**HIV/AIDS tests and results** *(initials)*	**Substance/alcohol abuse** *(initials)*
Mental/behavioral health *(initials)*	**This request is being made for:**	

SECTION E. EXPIRATION *(when this authorization will end)*

☐ **This authorization will expire one year from the date on which it was signed.**

☐ **This authorization will expire on the following date or event specified:** **Date** *(mm/dd/yyyy)*:

SECTION F. REVOCATION

I understand that I have the right to revoke this authorization at any time, and that if I revoke this authorization, I must send a written request to our third-party administrator: PayerFusion Holdings, LLC, 5200 Blue Lagoon Drive, Suite 100, Miami, Florida 33126, attention Claims Department. I understand that the revocation will not apply to information that has already been released in reliance on this authorization.

SECTION G. APPROVAL *(you or your personal representative must sign and date this form in order for it to be complete)*

I understand that this authorization is voluntary. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment of claims, enrollment or eligibility for benefits.

I also understand that if the person or organization that I authorize to receive the information described above is not subject to federal privacy laws, it may be re-disclosed by such person or organization and may no longer be protected by federal privacy laws. However, under federal and state laws, the recipient may be prohibited from re-disclosing substance abuse and HIV/AIDS information without a specific written consent of the person to whom it pertains, or as otherwise permitted by such laws.

Signature of Member/Personal Representative: By signing below, I authorize the release of my protected health information as described above.

Print name:	**Signature:**	**Date** *(mm/dd/yyyy)*:
Relation to member:		

The member is unable to consent because (select one):

☐ **Minor**

☐ **Incompetent**

Other *(explain)*

You are entitled to a copy of this authorization after you sign it.