AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Notice to Member:

- Completing this form will allow **Nebraska Total Care** to share your health information with the person or group that you identify below.
- You do not have to sign this form or give permission to share your health information. Your services and benefits with **Nebraska Total Care** will not change if you do not sign this form.
- Right to cancel (revoke): When you want to cancel this Authorization Form, fill out the Revocation Form on the next page and mail it to us at the address at the bottom of the page.
- **Nebraska Total Care** cannot promise that the person or group you want to share your health information with will not share it with someone else.
- Keep a copy of all completed forms that you send to us. **Nebraska Total Care** can send you copies if you need them.
- Fill in all the information on this form. When finished, mail it to the address at the bottom of the page.

Member Information:

Member Name (print): _____

Member Date of Birth: _____ Member ID Number: _____ **I give Nebraska Total Care permission to share my health information with the person or group (recipient) named below. The purpose of the authorization is to help me with Nebraska Total Care benefits and services.**

Recipient Information:

Name (person or group): _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Nebraska Total Care <u>can share this Health Information: (check all boxes that apply)</u>

- ☐ All of my PHI; **OR**
- ☐ All of my PHI **EXCEPT**:
  - ☐ Prescription drug/medication information
  - ☐ Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) information
  - ☐ Treatment for alcohol and/or substance abuse information
  - ☐ Behavioral health services or psychiatric care information
  - ☐ Other: _____

Authorization End Date: _____
(date the authorization ends unless cancelled)

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 personal representative, describe this below and send us copies of those forms (such as power of attorney or court order of guardianship).

Relationship: _____

Mail To:
Nebraska Total Care
Attn: Privacy Officer
2525 N. 117th Ave., Suite 100
Omaha, NE, 68164

Phone: 1-844-385-2192 (TTY 711)