Need to share your health information?

If anyone helps you with your healthcare — or you'd like someone to — this form can help. It lets us share your health information with them so they can take part in your care.

You control who sees your health information.

And that's a good thing. Details about your health can be very personal — and not just anyone is allowed to look at it. In fact, it's called *protected health information (PHI)* because there are laws about who can access it.

Your protected health information includes things like health conditions (physical and mental), notes from doctor's visits, and test results. It also includes details about your health insurance, like your plan, benefits, billing, and payments.

We have this information because we're a healthcare company. And keeping it safe is something we take seriously.

When would I want to share my information?

You might want a family member, friend, or someone else you trust to help with your healthcare. For example:

- You want your spouse to call and check on a claim for you
- You suddenly don't feel well and need a close friend to call and talk to one of our nurses for you
- You want one of your children to help handle your care and talk to us about your plan and benefits

Before any of that can happen, we need your OK to share your information with that person.

Who can I share it with?

Anyone you trust enough to help with your healthcare. Keep in mind that not every person or organization you share your information with has to follow privacy laws. So some can share your information again without asking you. To keep yourself protected, you may want to check state and federal laws.

When does this form expire?

One year after your last day as a Devoted Health member, unless you choose a different date on the form. Even after signing this form, you can end it at any time by sending a letter to:

FLORIDA:
Devoted Health – Enrollment
PO Box 211157
Eagan, MN 55121

ALL OTHER STATES:
Devoted Health – Enrollment
PO Box 211127
Eagan, MN 55121

Note that ending your consent won't affect information that's already been shared.

Do I have to fill out this form?

No. You need it only if there's a person or organization you want us to share your health information with. If that's not that case, you can skip this form. And either way, it won't affect your coverage.

Consent for Release of Protected Health Information (PHI)

Tell us how to share your PHI.

Devoted HEALTH PLANS

Your Details

Last Name: | First Name: | M.I.

Birth Date: MM / DD / YYYY

Member ID:

Address:

City: | State: | Zip:

What to Share

Choose only one.

- [ ] **All standard information.** This includes your health conditions, treatments, prescription drugs, billing details, and more. It covers just about everything.
- [ ] **Limited information.** Tell us what you want to share. For example, maybe it's information only about a specific health condition or from a certain period of time. Or only certain kinds of information, like medical, pharmacy, or billing details.

No matter which option you chose above, we can share certain details only if you specifically tell us to. Check any of the following you'd like to share:

- [ ] AIDS or HIV tests and treatment records
- [ ] Drug and alcohol abuse treatment records
- [ ] Genetic information, like results from gene testing
- [ ] Mental health treatment records

End Date. This form stays in effect until 1 year after your last day as a Devoted Health member. If not, enter a new end date or event here. An end event could be something like finishing treatment for a certain health condition.

Name: **Birth Date:**

Who to Share With

Legal Representatives: Include proof that you can act for the member, such as a healthcare power of attorney, healthcare surrogate form, living will, or guardianship papers.

Last Name: **First Name:** **M.I.**

Organization Name:

Birth Date: / /

Phone Number:

Address:

City: **State:** **Zip:**

Email:

Relationship to you:

- ☐ Spouse
- ☐ Parent
- ☐ Agent/Broker
- ☐ Sibling
- ☐ Child
- ☐ Friend
- ☐ Other _____

By signing this form, I'm agreeing that Devoted Health can share the information I've chosen with the person or organization listed.

Signature: (yours or your legal representative's) **Date:**

Printed Name: (yours or your legal representative's)

Please send your completed form to:

FLORIDA:

Mail
Devoted Health – Enrollment
PO Box 211157
Eagan, MN 55121

Fax
1-833-434-0535

ALL OTHER STATES:

Mail
Devoted Health – Enrollment
PO Box 211127
Eagan, MN 55121

Fax
1-877-264-3859