NextLevelHealth
A healthier you. A healthier community.

Authorization to Release Protected Health Information (PHI)

Protected Health Information (PHI) is private information about your health that cannot be shared with **anyone** without your permission. Federal and State laws protect the privacy of your health information to keep you safe. By signing this form, you give us permission to communicate with your family, caregiver, employer or others about your health conditions. We will only share the PHI that you give us permission to share. We will only give your PHI to the people or agencies that you have listed on this form.

Please print the following information:

1. **Who is the Medicaid Member?**

First Name	**Middle Initial**	**Last Name**
Member ID Number	**Phone Number**	**Birth Date (MM/DD/YYYY)**
Street Address	**City, State, Zip Code**	

2. **Who can your PHI be given to?**

Person or Company Name	**Phone Number**
Street Address	**City, State, Zip Code**
Person or Company Name	**Phone Number**
Street Address	**City, State, Zip Code**
Person or Company Name	**Phone Number**
Street Address	**City, State, Zip Code**

NOTICE TO ANYONE OTHER THAN THE MEMBER:
A person choosing to release their medical information to you does NOT give you permission to share their information with anyone else. You may not report health information about anyone without written permission from the person the information is about. You may not report information of a person experiencing treatment for alcohol or drug abuse, HIV/AIDS and other sexually transmitted diseases, behavioral health, and genetic marker information. Any unauthorized reporting could be against state or federal laws and could result in a fine, jail sentence, or both.

Some health information, such as treatment for drug or alcohol abuse, **cannot** be used to investigate or prosecute any alcohol or drug abuse patient. See the federal rule at 42 CFR Part 2 for more information.

3. **What PHI can we share?**

Please turn over to complete form

We will only share the PHI that you OK. Tell us the type of PHI you are willing to share by checking the box:
☐ Any information requested
☐ Health (medical, dental, pharmacy, vision)
☐ Mental health, but **NOT** psychotherapy notes
☐ Substance use disorder diagnosis and treatment. This does NOT include psychotherapy/counseling notes related to substance use disorder diagnosis and treatment
☐ Long term care
☐ Patient management records
☐ Other (please explain):

4. **Who can the PHI be given to?**

Reason/Purpose:

5. **This form is good for 1 year unless you give a shorter time below.**

My OK is good from:
_____ **TO** _____ **MM/DD/YY** **MM/DD/YY**

Please turn over to complete form.

By signing below, I understand and agree:

- I can take back my **OK** by writing to the address on this form.
- Taking back my OK won't take away the PHI that was already shared. However, no more of your PHI will be shared.
- My chance to sign up for insurance will not change if I don't sign this form.
- Whoever gets my PHI might share it with others. That means laws may not be able to protect my PHI.
- The PHI I **OK** to share includes:
    - Health conditions and treatment information
    - Chronic diseases
    - Mental health conditions
    - Substance use disorder diagnosis or treatments
    - Transmissible diseases, sexually transmitted diseases (HIV/AIDS), and genetic marker information
- I can get a copy of this OK by writing to the address on this form
- NextLevel Health Partners, Inc. will not share my PHI with anyone. That includes those named on this form, unless I sign this form.

ATTENTION:

- I must sign this form if any of the options below apply:
    - I am 18 years of age or older
    - I am under 18 years of age and I am married or emancipated
    - My state allows me to be treated even if my parents or legal guardians do not agree

- My PHI being shared may include one or more of the below conditions:
    - Substance use disorder diagnosis treatment
    - Mental health conditions
    - Sexually transmitted disease (including HIV/AIDS)
    - Reproductive health (including contraception, prenatal care and abortion)

6. **Signature of Member or Authorized Representative:**

Signature: **Date:**

_____ _____

Print Name:

Please turn over to complete form.

_____

If a legal representative signed this form, describe the relationship: (Parent, Legal Guardian, Power of Attorney, Personal Representative):

_____

Authorized Representative means you have legal proof that you can act for this person. A representative sign for a person who cannot legally sign on his or her own. If the member is less than 18 years old, a parent or guardian should sign for the minor. If you are a representative signing this form, you must send legal proof you can act for this person.

Do you have questions? We can help. Call NextLevel Health Partners, Inc., at the number found on the back of your ID card.

Please sign and return this completed form to:

NextLevel Health Partners
Member Services Department
224 S. Michigan Ave., Suite 700
Chicago, IL 60604
Or fax it to: 312-767-2544

For internal use only ☐ Approved ☐ Denied