



## AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION AND TO HANDLE CARECENTRIX ACCOUNTS

I authorize CareCentrix, Inc. (CareCentrix) and its affiliates to release my protected health information (PHI) contained in the records maintained by CareCentrix or a CareCentrix affiliate as specified below to the individual or entity identified below.

### Name and address of individual whose PHI is being disclosed:

**\*\*IMPORTANT\*\*** All fields with an asterisk must be completed.

\*Name: \_\_\_\_\_

\*Address: \_\_\_\_\_

\*City: \_\_\_\_\_ \* State: \_\_\_\_\_ \* Zip Code: \_\_\_\_\_

\*Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ \*Phone Number: (\_\_\_\_)\_\_\_\_-\_\_\_\_

\*Insurer: \_\_\_\_\_ \*Insurer ID Number: \_\_\_\_\_

CareCentrix Account Number (####-####): \_\_\_\_\_

### Name and address of individual/entity to whom the PHI is to be disclosed (Authorized Person):

\*Name: \_\_\_\_\_

\*Address: \_\_\_\_\_

\*City: \_\_\_\_\_ \* State: \_\_\_\_\_ \* Zip Code: \_\_\_\_\_

\*Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ \*Phone Number: (\_\_\_\_)\_\_\_\_-\_\_\_\_

\*Relationship to Patient: \_\_\_\_\_

I agree that my PHI may be disclosed to the Authorized Person through various means of communication, including but not limited to, by phone, email, fax and US mail. The purpose for the disclosure of PHI is to discuss my health care services and treatment plan and/or handle my accounts with CareCentrix, including but not limited to, my patient billing account. I further agree that the Authorized Person has full authority to handle my patient billing and other accounts with CareCentrix, including but not limited to, receiving copies of invoices and billing ledgers, making payments, receiving refunds of any overpayments, and making changes to my account information.

I understand that the above information to be disclosed under this authorization may contain information about HIV, AIDS diagnosis/treatment, mental health diagnosis/treatment, alcohol/drug diagnosis/treatment, developmental disability, and/or abuse, and I expressly authorize the disclosure of such information unless otherwise specifically indicated below:



Do not disclose any information about:

- ☐ HIV/AIDS diagnosis/treatment   ☐ Alcohol/drug diagnosis/treatment  
☐ Mental health diagnosis/treatment   ☐ Developmental disability   ☐ Abuse

I understand that I have a right to revoke this authorization at any time by contacting CareCentrix in writing, except to the extent information has been released in reliance upon this authorization. I also understand that the information released in response to this authorization may be re-disclosed to other parties and no longer protected by the federal Privacy Rule. I understand that my treatment, payment for treatment, or enrollment or eligibility for benefits with my insurer cannot be conditioned on the signing of this authorization. I understand that the information requested is the property of CareCentrix and that a reasonable fee may be charged for the copying of any such records. Any facsimile or photocopy of this authorization shall authorize CareCentrix and its affiliates to disclose the information requested herein. This authorization shall be effective as of the date of execution set forth below and remain in effect for a period of five years at which time this authorization expires.

\*Signature: \_\_\_\_\_

\*Date: \_\_\_\_\_

\*Printed Name: \_\_\_\_\_

If signed by anyone other than the patient, relationship of authorized representative to individual:

\_\_\_\_\_

If authorized representative of the individual please attach corresponding authorization documentation (power of attorney, etc.).

**Please mail completed form to (both pages must be included)**

**CareCentrix, Inc.  
Attention: Mail Room  
9119 Corporate Lake Drive, Suite 200  
Tampa, FL 33634**

**Or Fax to:  
Fax Number: (866) 536-8046**

**Or Email to:  
[authorizationtodisclosephirequest@carecentrix.com](mailto:authorizationtodisclosephirequest@carecentrix.com)**

## **Multi-Language Insert**

### **Multi-Language Interpreter Services**

**Spanish:** Contamos con servicios de interpretación gratuitos para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o de medicamentos. Para obtener un intérprete, simplemente llámenos a los números del plan que figuran en las siguientes páginas. Alguien que hable español puede ayudarle. Este es un servicio gratuito.

**Chinese Mandarin:** 我们有免费的口译服务来回答您就我们的健康或药物计划提出的任何问题。如需口译员，只需拨打以下页面上的计划号码致电联系我们。会说中文普通话的人员可以协助您。此为免费服务。

**Chinese Cantonese:** 我們有免費的口譯服務來回答您就我們的健康或藥物計劃提出的任何問題。如需口譯員，只需撥打以下頁面上的計劃號碼致電聯絡我們。會說粵語的人員可以協助您。此為免費服務。

**Tagalog:** Meron kaming libreng serbisyo ng interpreter para sagutin anumang tanong na meron ka tungkol sa aming plano ng kalusugan o gamot. Para makakuha ng interpreter, tawagan lang kami sa mga numero ng plano na nasa sumusunod na mga pahina. Matutulungan ka ng sinumang nagsasalita ng Tagalog. Libreng serbisyo ito.

**French:** Nous disposons de services d'interprétation gratuits pour répondre à toutes les questions que vous pourriez vous poser au sujet de notre régime de soins médicaux ou de notre régime d'assurance-médicaments. Pour bénéficier des services d'un interprète, il suffit de nous appeler aux numéros de régime indiqués dans les pages suivantes. Quelqu'un qui parle français peut vous aider. Ce service est gratuit.

**Vietnamese:** Chúng tôi cung cấp dịch vụ phiên dịch viên miễn phí để trả lời bất kỳ câu hỏi nào quý vị có về chương trình y tế hoặc thuốc của chúng tôi. Để nhận được dịch vụ phiên dịch, chỉ cần gọi cho chúng tôi theo số điện thoại của chương trình trong các trang sau. Người nào đó nói tiếng Việt có thể giúp quý vị. Đây là dịch vụ miễn phí.

**German:** Wir bieten Ihnen einen kostenlosen Dolmetscherdienst, um alle Ihre Fragen zu unserem Gesundheits- oder Medikamentenplan zu beantworten. Um einen Dolmetscher zu finden, rufen Sie uns einfach unter den auf den folgenden Seiten angegebenen Plan-Nummern an. Jemand, der Deutsch spricht, kann Ihnen helfen. Dieser Service ist für Sie kostenlos.

**Korean:** 저희의 건강 또는 약품 플랜에 대한 질문에 대해 드릴 수 있는 무료 통역 서비스를 제공합니다. 통역사에게 연결하려면 다음 페이지에 있는 플랜 번호로 전화하시기 바랍니다. 한국어를 하는 분이 도와드릴 수 있습니다. 이 통화는 무료 서비스입니다.

**Russian:** Мы предоставляем бесплатные услуги устного перевода, чтобы ответить на любые вопросы, которые могут возникнуть у вас о нашем плане медицинского страхования или страхового покрытия лекарственных препаратов. Чтобы получить устного переводчика, просто позвоните нам по номерам планов, указанным на следующих страницах. Вам поможет тот, кто говорит по-русски. Эта услуга предоставляется бесплатно.



**Arabic:** نوفر خدمات مترجم فوري للإجابة عن أي أسئلة قد تكون لديك حول خطتنا الصحية أو الدوائية. للاستعانة بمترجم، ما عليك سوى الاتصال بنا على أرقام الخطة في الصفحات التالية. شخص يتحدث العربية يمكنه مساعدتك. هذه الخدمة تقدم مجاناً.

**Hindi:** हमारे स्वास्थ्य या दवा योजना के बारे में आपके होने वाले किसी भी प्रश्न का उत्तर देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएं उपलब्ध हैं। दुभाषिया प्राप्त करने के लिए, हमें निम्नलिखित पृष्ठों पर दिए गए प्लान नंबरों पर कॉल करें। कोई हिंदी भाषी व्यक्ति आपकी मदद कर सकता है। यह एक निःशुल्क सेवा है।

**Italian:** Disponiamo di servizi di interpretariato gratuiti per rispondere ad eventuali domande in merito al nostro piano sanitario o farmaceutico. Per ottenere un interprete, chiami i recapiti del piano disponibili nelle pagine successive. Qualcuno che parla italiano Le sarà d'aiuto. Si tratta di un servizio gratuito.

**Portugués:** Temos serviços de intérprete gratuitos para responder quaisquer perguntas que você possa ter sobre nossos planos de saúde ou de medicamentos. Para solicitar um intérprete, ligue para nós através dos números do plano nas páginas a seguir. Um funcionário que fala português poderá ajudá-lo. Este serviço é gratuito.

**French Creole:** Nou gen sèvis entèprèt gratis pou reponn tout kesyon ou ka genyen konsènan plan sante oswa plan medikaman nou an. Pou jwenn yon entèprèt, annik rele nou nan nimewo plan yo ki sou paj annapre yo. Yon moun ki pale Kreyòl Franse kapab ede ou. Se yon sèvis gratis li ye.

**Polish:** Oferujemy bezpłatne usługi tłumaczeniowe w przypadku pytań dotyczących naszego planu zdrowotnego i lekowego. Aby skorzystać z tłumacza, prosimy zadzwonić do nas pod numery podane na kolejnych stronach. Pomocą posłużą osoby mówiące po polsku. Usługa jest bezpłatna.

**Japanese:** 当社の医療プランまたは処方薬プランについての質問にお答えする無料の通訳サービスをご利用いただけます。通訳サービスをご利用になるには、以降のページにおけるプランの番号までお電話ください。日本語を話すスタッフが対応いたします。これは無料のサービスです。

**Hawaiian:** Aia iā mākou he mau lawelawe māhele 'ōlelo manuahi e pane i nā 'ano nīnau āu no ka mākou papahana mālama olakino a ho'olako lā'au. No ka 'imi i mea māhele 'ōlelo, e kelepona wale mai iā mākou ma nā helu kelepona e waiho nei ma kēia mau 'ao'ao e koe nei. Na kekahi māhele 'ōlelo Hawai'i e kōkua iā 'oe. He lawelawe manuahi kēia.

**Ilocano:** Addaankami kadagiti libre a serbisio ti panagipatarus tapno masungbatan dagiti aniaman a saludsodmo maipapan iti salun-at wenno plano iti agas. Tapno makaala iti tagaipatarus, tawagannakami laeng kadagiti numero ti plano kadagiti sumaganad a panid. Matulongannaka ti maysa a tao nga agsasao iti Ilocano. Daytoy ket libre a serbisio.

**Samoaan:** E iai a matou auaunaga fa'aliliu upu fua e tali ai so'o se fesili e te ono iai e uiga i la matou fuafuaga fa'alesoifua maloloina po'o vaila'au. Mo le mauaina o se fa'aliliu upu, na'o le vala'au mai i numera o fuafuaga o lo'o i itulau nei. E mafai e se tasi e tautala i le gagana Samoa ona fesoasoani ia te oe. Ose auaunaga e leai se totagi.