Authorization for the Use and Disclosure of Protected Health Information

MEMBER INFORMATION (person whose information will be released)

First Name: ______________________ Last Name: ______________________

Member ID: ______________________ Date of Birth: ______________________

Address: ______________________ City: ____________________ State: ______

I understand that this Consent of Release will allow Doctors Healthcare Plans to use or disclose my Protected Health Information (PHI), including my medical, dental, and pharmacy information, as I authorize below:

☐ All Protected Health Information (PHI) - clinical, claims, billing, benefit, and coverage information
This authorizes the release of behavioral health, HIV, and substance use information, unless restricted below.

☐ Other (specify here): ____

***RESTRICTIONS** (select all that apply, if any)

I restrict the following type of PHI from being released under this Authorization:

☐ Mental health ☐ HIV ☐ Substance Use

I authorize the above selected information to be disclosed to the following:

Name: ______________________ Last Name: ______________________

Relationship: ______________________ Date of Birth: ______________________

Address: ______________________ City: ____________________ State: ______

I understand that unless otherwise revoked in writing, this authorization will expire 12 months from the date of my signature. I understand I have the right to revoke this authorization at any time. I understand that if I revoke this Authorization, I must do so in writing and present my written request to Doctors Healthcare Plans' Member Services Department. I understand that the revocation will not apply to information that has been released in response to this authorization. I understand that after the information is disclosed under this authorization, it can be redisclosed by the recipient and the information may not be protected by federal privacy regulations.

I understand I do not have to sign this Authorization, and that Doctors HealthCare Plans can not base treatment or payment decisions on whether I sign this Authorization. I understand that a copy of this Authorization may be utilized with he same effectiveness as an original and that I am entitled to receive a copy of this Authorization.

______________________________________ ______________________

Member or Legal Representative* Signature Date

**Legal Representative(s) must provide documentation to support legal authority to act on behalf of Member.*

Legal Representative Name: ______________________ Phone: ______________________

Address: ______________________ City: ____________________ State: ______

DOCTORS
HEALTHCARE PLANS, INC.

DISCRIMINATION IS AGAINST THE LAW

Doctors HealthCare Plans, Inc., complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Doctors HealthCare Plans, Inc., does not exclude individuals or treat them differently because of race, color, national origin, age, disability, or sex.

Doctors HealthCare Plans, Inc. provides: (1) free aids and services to people with disabilities to communicate effectively with us, such as, qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats); and, (2) free language services to individuals whose primary language is not English, such as, qualified interpreters and information written in other languages.

If you need these services, contact the number on the back of your ID Card. If you believe that Doctors HealthCare Plans, Inc., has failed to provide these services or discriminated in any way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: **Doctors HealthCare Plans, Inc.,** *Attention: Member Services Department*, 2020 Ponce de Leon Blvd., PH 1, Coral Gables, FL 33134 or call (786) 460-3427 or (833) 342-7463, TTY: 711; fax: (786) 578-0283, 7 days a week; 8AM to 8PM EST.

You can file a grievance in person, by mail, or by fax. If you need help filing a grievance, our Member Services Representatives are available to help you at the number listed above. You can also file a civil rights complaint electronically through the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201 or call (800) 368-1019, (800) 537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

MULTI-LANGUAGE INTERPRETER SERVICE:

English: ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 786-460-3427 or 833-342-7463 (TTY: 711). **Español (Spanish):** ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 786-460-3427 o 833-342-7463 (TTY: 711). **繁體中文 (Chinese):** 注意：如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 Call 786-460-3427 or 833-342-7463 (TTY: 711). **Français (French):** ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 786-460-3427 or 833-342-7463 (TTY: 711). **Deutsch (German):** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 786-460-3427 or 833-342-7463 (TTY: 711). ગુજરાતી **(Gujarati):** **સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો** 786-460-3427 or 833-342-7463 (TTY: 711). **Kreyòl Ayisyen (French Creole):** ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pouou. Rele 786-460-3427 or 833-342-7463 (TTY: 711). **Italiano (Italian):** ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 786-460-3427 or 833-342-7463 (TTY: 711). **한국어 (Korean):** 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 786-460-3427 or 833-342-7463 (TTY: 711).번으로 전화해 주십시오. **Polski (Polish):** UWAGAM: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 786-460-3427 or 833-342-7463 (TTY: 711). **Português (Portuguese):** ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 786-460-3427 or 833-342-7463 (TTY: 711). **Русский (Russian):** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 786-460-3427 or 833-342-7463 (TTY: 711). **ภาษาไทย (Thai):** เรียน: ถา้คุณพดูภาษาไทยคุณสามารถใชบ้ริการช่วยเหลือทางภาษาไดฟ้รี โทร 786-460-3427 or 833-342-7463 (TTY: 711). **Tiếng Việt (Vietnamese):** CHÚ Ý: Nu bn nói Ting Vit, có các dch v h tr ngôn ng min phí dành cho bn. Gi s 786-460-3427 or 833-342-7463 (TTY: 711). **Tagalog (Tagalog – Filipino):** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 786-460-3427 or 833-342-7463 (TTY: 711). **Diné Bizaad (Navajo):** ANOMPA PA̲ PISAH: [Chahta] makilla ish anompoli hokma̲, kvna hosh Nahollo Anompa ya̲ pipilla hosh chi̲ tosholahinla. Atoko̲, hattak yvmma̲ im anompoli chi bvnnakmvt, holhtina pa̲ pa̲yah: 786-460-3427 or 833-342-7463 (TTY: 711). العربية **(Arabic):**

تنبيه: إذا لم تكن تتحدث الإنجليزية، نوفر خدمات المساعدة اللغوية مجانًا من أجلك. اتصل بالرقم 786-460-3427 أو 833-342-7463 (هاتف نصي:711)