P.O. Box 569008
Miami, FL 33256-9906
MDC-JHS Dedicated Service Unit: 1-800-682-8633

MEMBER'S AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Please complete all of the following information:

Member Name: ______________________ AvMed ID Number: ______________________

Address: ______________________ Telephone: ( ) ______________________

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I authorize AvMed to disclose information about me, as indicated below, to the following individual(s):

Name of Individual: (please print clearly) Relationship to Member:

______________________ ______________________

______________________ ______________________

I authorize AvMed to disclose the following information about me to the above named individual(s): (check all that apply ☑)

- ❒ Eligibility/Benefit Information
- ❒ Authorization Information
  - ❒ All
  - ❒ Specific Dates (provide dates):

  ____
- ❒ Claims Information
  - ❒ All
  - ❒ Specific Dates (provide dates):

  ____
- ❒ Pharmacy Claims (Prescription) Information
  - ❒ All
  - ❒ Specific Dates (provide dates):

  ____
- ❒ Participation in Care Management Programs
  - ❒ All
  - ❒ Specific Dates (provide dates):

  ____

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This information may be disclosed by AvMed for the following purpose(s): (*Note*: If you elect not to provide a specific statement of purpose, you may write "at my request" in the space provided below.)

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This authorization will remain in effect by the date indicated below: (*check* one)

- ❒ Signature date until the date of my disenrollment from AvMed Health Plans
- ❒ Specific Date: (provide date) ______________________________
- ❒ Other: (describe) ______________________________

I hereby authorize the disclosure of my PHI as described above. I understand the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal privacy regulations.

Note - This general authorization is not intended to serve as a release for medical information or records related to certain special conditions and events, which may include, but are not limited to psychiatric or psychotherapeutic counseling and treatment; rehabilitation, alcohol or drug abuse dependency; HIV testing, diagnosis, or treatment; and genetic testing results.

This authorization is voluntary and you can refuse to sign this authorization. You have the right to revoke any written authorization, except to the extent that we have taken action in reliance on the authorization, by writing to us at: AvMed Health Plans, Member Services Department, P.O. Box 569008, Miami, FL 33256-9906.

AvMed Health Plans may not condition your receipt of treatment, payment, enrollment, or eligibility for benefits on completion of this authorization.

I hereby certify that I am the afore-named AvMed member. I understand that this authorization is not valid without my signature.

Signature:______________________________ **Date**:____________________

Or:

I hereby certify that I am the appointed representative of the above named AvMed member. I have attached the following documentation of my appointment as representative: (describe documentation)

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Representative Name: (please print)______________________________

Signature:______________________________ **Date**:____________________