Information to Help You Fill Out the Fidelis Care Authorization to Disclose Personal Health Information Form

By law, Fidelis Care must have your written permission (an “authorization”) to use or give out your personal medical information for any purpose that isn't set out in the privacy notice contained in the Fidelis Care handbook. You may take back (“revoke”) your written permission at any time, except if Fidelis Care has already acted based on your permission.

If you want Fidelis Care to give your personal health information to someone other than you, you need to let Fidelis Care know in writing.

If you are requesting personal health information for a deceased beneficiary, please include a copy of the legal documentation which indicates your authority to make a request for information. (For example: Executor/Executrix papers, next of kin attested by court documents with a court stamp and a judge's signature, a Letter of Testamentary or Administration with a court stamp and judge’s signature, or personal representative papers with a court stamp and judge's signature.) Also, please explain your relationship to the beneficiary.

Please use this step-by-step instruction sheet when completing your Fidelis Care Authorization to Disclose Personal Health Information Form. Be sure to complete all sections of the form to ensure timely processing.

1. Print the name of the person with Fidelis Care.

   Print the Fidelis Care Member ID number exactly as it is shown on the Fidelis Care card (for example, 123456789).

   Print the birthday in month, day, and year (mm/dd/yyyy) of the person with Fidelis Care.

2. This section tells Fidelis Care what personal health information to give out. Please check a box in 2A to indicate how much information Fidelis Care can disclose. If you only want Fidelis Care to give out limited information (for example, Fidelis Care eligibility), also check the box(es) in 2B that apply to the type of information you want Fidelis Care to give out.
3. This section tells Fidelis Care when to start and/or when to stop giving out your personal health information. Check the box that applies and fill in dates, if necessary.

4. Fidelis Care will give your personal health information to the person(s) or organization(s) you fill in here. You may fill in more than one person or organization. If you designate an organization, you must also identify one or more individuals in that organization to whom Fidelis Care may disclose your personal health information.

5. The person with Fidelis Care or personal representative must sign their name, fill in the date, and provide the phone number and address of the person with Fidelis Care.

6. If you are a personal representative of the person with Fidelis Care, check the box, provide your address and phone number, and attach a copy of the paperwork that shows you can act for that person (for example, notarized Power of Attorney).

7. Send your completed, signed authorization to Fidelis Care at the address shown on your authorization form. A fax number is also provided.

8. If you change your mind and don't want Fidelis Care to give out your personal health information, write to the address shown under number 6 on the authorization form and tell Fidelis Care. Your letter will revoke your authorization and Fidelis Care will no longer give out your personal health information (except for the personal health information Fidelis Care has already given out based on your permission).

You should make a copy of your signed authorization for your records before mailing it to Fidelis Care.

9. **Notice to law firms, record retrieval agencies, and third party insurance entities requesting a claims payment report for litigation or subrogation purposes, please note: you must submit a notarized authorization to receive records.**
Fidelis Care Authorization to Disclose Personal Health Information

Use this form if you want Fidelis Care to give your personal health information to someone other than you.

1. ___________________________________________  Fidelis Care Member ID Number  Date of Birth
   (First and last name of the person with Fidelis Care)  (Exactly as shown on Fidelis Care Member ID Card)  (mm/dd/yyyy)

2. Fidelis Care will only disclose the personal health information you want disclosed.

   2A: Check only one box below to tell Fidelis Care the specific personal health information you want disclosed:
   - [ ] Limited Information (go to question 2B)
   - [ ] Any Information (go to question 3)

   2B: Complete only if you selected “limited information”. Check all that apply:
   - [ ] Information about your eligibility
   - [ ] Information about your claims
   - [ ] Information about plan enrollment (e.g. drug plan)
   - [ ] Information about premium payments
   - [ ] Information about mental health records
   - [ ] Information about communicable diseases (including HIV and AIDS)
   - [ ] Information about alcohol/drug abuse treatment
   - [ ] Other Specific Information (please write below; for example, payment information)
   ____________________________________________________________

3. Check only one box below indicating how long Fidelis Care can use this authorization to disclose your personal health information (subject to applicable law):
   - [ ] Disclose my personal health information indefinitely
   - [ ] Disclose my personal health information for a specified period only beginning: (mm/dd/yyyy) ______________ and ending: (mm/dd/yyyy) ______________

4. Fill in the name and address of the person(s) or organization(s) to whom you want Fidelis Care to disclose your personal health information. It is not necessary to include your physician(s) or pharmacy. Please provide the specific name of the person(s) for any organization you list below:

   1. Name: _____________________________  2. Name: _____________________________
      Address: _____________________________  Address: _____________________________
      _____________________________  _____________________________
      Phone: _____________________________  Phone: _____________________________
5. **I authorize Fidelis Care to disclose my personal health information listed above to the person(s) or organization(s) I have named on this form. I understand that my personal health information may be re-disclosed by the person(s) or organization(s) and may no longer be protected by law.**

<table>
<thead>
<tr>
<th>Signature</th>
<th>Telephone Number</th>
<th>Date (mm/dd/yyyy)</th>
</tr>
</thead>
</table>

Print the address of the person (Street Address, City, State, and ZIP)

__________

☐ Check here if you are signing as a personal representative and complete below. Please attach the appropriate documentation (for example, notarized Power of Attorney). This only applies if someone other than the person signed above.

Print the Personal Representative's Address (Street Address, City, State, and ZIP)

__________

Telephone Number of Personal Representative: ________________________

Personal Representative's Relationship to the Beneficiary: ________________________

6. **Send the completed, signed authorization via:**

   **Mail:**
   Fidelis Care Member Services  
   95-25 Queens Blvd 7th Floor  
   Rego Park, NY 11374

   **Fax:** (718) 896-6832

7. **Additional Rights:**

   You have the right to take back ("revoke") your authorization at any time, in writing, except to the extent that Fidelis Care has already acted based on your permission. If you would like to revoke your authorization, send a written request to the address shown above.

   Your authorization or refusal to authorize disclosure of your personal health information will have no effect on your enrollment, eligibility for benefits, or the amount Fidelis Care pays for the health services you receive.

8. **Notice to law firms, record retrieval agencies, and third party insurance entities requesting a claims payment report for litigation or subrogation purposes, please note:** you must submit a notarized authorization to receive records.