FirstChoice VIP CARE PLUS®
by Select Health of South Carolina

Authorization for Sharing Health Information

Please print clearly in blue or black ink.

This form is used to share your protected health information ("PHI") where your authorization is required by federal and state privacy laws. Your authorization allows First Choice VIP Care Plus (Medicare-Medicaid Plan) to share your PHI with the person(s) or organization(s) that you choose. You can also choose to allow the person(s) or organization(s) to share your PHI with First Choice VIP Care Plus. You can cancel this authorization at any time by contacting First Choice VIP Care Plus. Call Member Services at **1-888-978-0862; (TTY 711)**, 8 a.m. to 8 p.m., seven days a week, for more information.

Part A. Member information (person whose PHI will be shared)			
Member first name:			Middle initial:
Last name:	Member ID (see ID card):		
Member street address:			
City:		State:	ZIP code:
Member date of birth:	Daytime phone number (with area code):		
Member email address :			

Part B. Recipient (person or organization that will receive your PHI)			
The following person or organization has the right to receive my PHI:			
Do you want the following person or organization to also share your PHI with us? ☐ Yes ☐ No			
First name:	Last name:		
Organization name (if applicable):			
Address:			
City:		State:	ZIP code:
Phone number (with area code):			
Relationship to member in Part A:			
Recipient email address:			

Part C. Description of the PHI to be shared

Tell us what types of PHI can be shared. You can check as many boxes as you want. At least one box must be checked. Note: Some sharing of PHI without your authorization is permitted by state and federal law.

☐ **Non-sensitive condition records.** All PHI related to my health and the provision of and payment for my health care benefits and services, **except for sensitive conditions as set forth below**.
Note: Federal law requires a separate authorization to share psychotherapy notes.

☐ **Sensitive condition records.** Some laws allow you to give specific permission to share sensitive PHI. Please check the boxes below for sensitive PHI that is OK to share. By checking these boxes, you give permission for all your records containing that type of PHI to be shared. If you only want to authorize sharing of a subset of records, such as records about only one diagnosis, fill out the "Only limited information" section on Page 2.

- ☐ Genetic information
- ☐ HIV/AIDS
- ☐ Substance or alcohol use
- ☐ Mental/behavioral health (including inpatient treatment)
- ☐ Sexually transmitted disease
- ☐ Abortion and family planning
- ☐ Communicable diseases

Part C. Description of the PHI to be shared (continued)

☐ **Only limited information.** In the box below, describe the PHI you want shared. Examples:

- The claim related to my service on [date]
- Appeal information related to my claim on [date]

Please describe the information you want shared:

Part D. Purpose of this authorization

This authorization is valid for sharing of PHI for the following purposes. (Please check one or both boxes.)

☐ To help diagnose, treat, manage, and/or pay for my health needs

OR

☐ For the following reason:

This authorization shall be invalid if used for any purpose other than the purpose(s) stated above.

Part E. Expiration date of this authorization

This authorization will expire: Please check only one box.

☐ I want the authorization to expire one (1) year after my coverage with First Choice VIP Care Plus ends. (See information below.)*

OR

☐ Upon the following date, event, or condition:*

* First Choice VIP Care Plus must be notified of the event/condition to cancel this authorization. In North Carolina and New Jersey, this authorization automatically expires one year after the date it was signed, unless you choose an earlier date. In New Hampshire, the authorization automatically expires two years after the date it was signed, unless you choose an earlier date. In Louisiana, if you are requesting the sharing of genetic information, the authorization expires 60 days after the date it was signed, unless you choose an earlier date. In the District of Columbia, if you are requesting the sharing of mental health information, the authorization automatically expires one year after the date it was signed, unless you choose an earlier date.

Part F. Approval: You OR your personal representative must sign and date this form in order for it to be processed.

I understand that this authorization for sharing my PHI is voluntary and is not a condition of enrollment in First Choice VIP Care Plus, eligibility for benefits, or payment of claims. I understand that I may cancel this authorization at any time by submitting a request to First Choice VIP Care Plus, and that canceling this authorization will not affect any action taken pursuant to the authorization prior to my request to cancel. I also understand that if I cancel this authorization, I should separately notify the individual(s) or organization(s) listed in Part B if I wish for those individual(s) or organization(s) to no longer share my PHI. I also understand that if the person or organization I authorize to receive my PHI described above is not subject to federal or state health information privacy laws, they may further share my PHI and it may no longer be protected by federal or state privacy laws. I also understand that I or my personal representative have a right to receive a copy of this form and to review my PHI that may be shared because of this authorization.

Authorization for Sharing Health Information

Member signature: By signing below, I authorize the sharing of my PHI as described above.	
Signature of member:	Date:

Personal representative information: By signing below, I authorize the sharing of PHI about the member listed above. (A personal representative is a person who has the legal authority to make health care decisions on the member's behalf. A copy of a power of attorney or other legal health care documents must be on file at First Choice VIP Care Plus or submitted with this form.)	
Printed name of personal representative:	
Address of representative:	
Description of personal representative's authority:	
Signature of personal representative:	
Date:	Phone number:
Return the completed form to: Consent Processing Center, P.O. Box 7092, London, KY 40742-7092 Fax number: **1-833-214-2242** (toll-free)	

Addendum to Authorization for Sharing Health Information

Verbal consent

We, the undersigned, attest that the member listed in Part A above is **physically unable** to sign this authorization. Verbal consent does not replace the need for documentation showing that another person is the member's personal representative, and cannot replace this documentation simply because it is inconvenient for the member to sign.

Reason the member is unable to sign:

The signatures below indicate:

- The information on this form was communicated to the member.
- The member indicated their understanding of the information in this authorization.
- The member freely gave their consent.

Method of communication to member:

☐ Phone

☐ In person

☐ Other (explain):

Witness printed name:	Witness printed name:
Witness signature:	Witness signature:
Date:	Date:

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Discrimination is Against the Law

First Choice VIP Care Plus complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. First Choice VIP Care Plus does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

First Choice VIP Care Plus

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact First Choice VIP Care Plus Member Services at 1-888-978-0862 (TDD/TTY: 711). We are available from 8 a.m. to 8 p.m., 7 days a week.

If you believe that First Choice VIP Care Plus has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

- First Choice VIP Care Plus Grievances and Complaints Department, P.O. Box 7140, London, KY 40742-7140. Phone: 1-888-978-0862 (TDD/TTY: 711), Fax: 1-855-238-0395.
- You can file a grievance by mail, fax, or phone. If you need help filing a complaint or grievance, First Choice VIP Care Plus Member Services is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the 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
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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Multi-Language Insert
Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-888-978-0862 (TTY: 711), 8 a.m. to 8 p.m., seven days a week. Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérpretes sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o de medicamentos. Para hablar con un intérprete, simplemente llame al 1-888-978-0862 (TTY: 711) de 8 a. m. a 8 p. m., los siete días de la semana. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费口译服务，以回答您对于我们的健康或药物计划的任何问题。如需口译服务，您只需要每周七天、每天上午 8 时到晚间 8 时拨打我们的电话 1-888-978-0862 (TTY 711)。会说中文的人将为您提供帮助。这项服务免费。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan maaaring mayroon kayo hinggil sa aming planong pangkalusugan o para sa gamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-888-978-0862 (TTY: 711), 8 a.m. hanggang 8 p.m., pitong araw sa isang linggo. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay isang libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-888-978-0862 (TTY: 711) de 8 h à 20 h, sept jours sur sept. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương trình sức khỏe hoặc chương trình thuốc men của chúng tôi. Nếu quí vị cần thông dịch viên, xin gọi 1-888-978-0862 (TTY: 711), 8 giờ sáng đến 8 giờ tối, bảy ngày một tuần. Sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-888-978-0862 (TTY: 711) an, von 8 Uhr bis 20 Uhr, sieben Tage die Woche. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

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Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 주 7 일 오전 8 시에서 오후 8 시 사이에 전화 1-888-978-0862(TTY: 711)번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового плана или покрытия лекарств, вы можете воспользоваться нашими бесплатными Услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-888-978-0862 (TTY: 711) с 8 утра до 8 вечера семь дней в неделю. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic:
إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بخطتنا الصحية أو العلاجية. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-888-978-0862 (TTY: 711)، من الساعة 8 صباحًا إلى الساعة 8 مساءً، على مدار أيام الأسبوع. ستحصل على المساعدة من قِبل شخص يتحدث باللغة العربية، مع العلم بأن هذه الخدمة مجانية.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-888-978-0862 (TTY: 711), fra le 8 a.m. e le 8 p.m., sette giorni la settimana. Un nostro incaricato che parla Italiano vi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer dúvida que você tenha acerca do nosso plano de saúde ou de medicação. Para solicitar um intérprete, entre em contato conosco através do número 1-888-978-0862 (TTY: 711), disponível todos os dias da semana das 8h às 20h. Você será auxiliado(a) por alguém que fala português. Esse serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa medikaman nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-888-978-0862 (TTY: 711), 8è nan maten pou 8è diswa, sèt jou sou sèt. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Oferujemy bezpłatne usługi tłumacza ustnego, który pomoże uzyskać odpowiedzi na temat planu zdrowotnego lub farmaceutycznego obejmującego leki i ich dawkowanie. Aby skorzystać z pomocy tłumacza mówiącego po polsku należy zadzwonić pod numer 1-888-978-0862 (TTY: 711), w godzinach od 8:00 do 20:00, siedem dni w tygodniu. Ta usługa jest bezpłatna.

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Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-888-978-0862 (TTY: 711) पर फोन करें सप्ताह के सातों दिन सुबह 8 बजे से रात 8 बजे तक. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Ukrainian: Ми надаємо безкоштовні послуги усного перекладу для відповіді на будь-які питання, які у вас можуть виникнути щодо нашого плану медичного або фармацевтичного страхування. Щоб скористатися послугою перекладача, просто зателефонуйте нам за номером 1-888-978-0862 (TTY: 711), з 8:00 до 20:00, 7 днів на тиждень. Хтось, хто володіє українською мовою, зможе вам допомогти. Це безкоштовна послуга.

Pashto:

مونږ د ترجمان خدمتونه په وړیا توګه وړاندې کوو څو تاسو ته د هغه ټولو پوښتنو ځواب درکړو، چې تاسو یې زمونږ د روغتیا یا درملو د پلان په اړه لرئ. د ترجمان ترلاسه کولو لپاره، مونږ ته په 1-888-978-0862 (TTY: 711) د اوونۍ اووه ورځې، سهار له 8 څخه ماخوستن تر 8 بجو پورې زنګ ووهئ. یو پښتو ویونکی کس به ستاسو سره مرسته وکړي. دا خدمت وړیا دی.

Bengali: আমাদের স্বাস্থ্য বা ওষুধের পরিকল্পনা সম্পর্কে আপনার যেকোনো প্রশ্নের উত্তর দেওয়ার জন্য আমাদের বিনামূল্যে দোভাষী পরিষেবা রয়েছে। একজন দোভাষী পেতে, আমাদেরকে শুধু 1-888-978-0862 (TTY: 711) নম্বরে ফোন করুন, 8 a.m. থেকে 8 p.m. পর্যন্ত, সপ্তাহে সাত দিন। বাংলায় কথা বলেন এমন কেউ আপনাকে সাহায্য করতে পারবেন। এই পরিষেবা বিনামূল্যে প্রদান করা হয়।

Farsi:

ما از خدمات مترجم شفاهی رایگان برخوردار هستیم تا پرسش های احتمالی شما در مورد طرح بیمه سلامت یا دارو پاسخ دهیم. جهت دریافت یک مترجم شفاهی، در هفت روز هفته از ساعت 8 صبح تا 8 شب فقط با شماره 1-888-978-0862 (TTY: 711) تماس حاصل فرمایید. فردی که به زبان فارسی صحبت می‌کند می‌تواند به شما کمک کند. این یک خدمت رایگان است.

Albanian: Ne kemi shërbime përkthimi falas për t'iu përgjigjur çdo pyetjeje që mund të keni në lidhje me planin tonë shëndetësor ose të ilaçeve. Për të patur një përkthyes, thjesht na telefononi në numrin 1-888-978-0862 (TTY: 711), 8:00-20:00, shtatë ditë në javë. Dikush që flet shqip mund t'ju ndihmojë. Ky është një shërbim falas pa pagesë.

Dari:

ما خدمات ترجمان همزمان رایگان را عرضه می‌کنیم تا به کدام سوالی که ممکن است شما در مورد پلان صحی یا دوایی داشته باشید جواب بدهیم. برای برخورداری از یک ترجمان همزمان، در هفت روز هفته از ساعت 8 صبح تا 8 شام کافی است از طریق نمبر 1-888-978-0862 (TTY: 711) با ما به تماس شوید. شخصی که به لسان دری صحبت می‌کند می‌تواند به شما کمک نماید. این سرویس رایگان است.

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Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-888-978-0862 (TTY: 711)にお電話ください。通訳サービスは毎日午前 8 時から、午後 8 時までで、日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

First Choice VIP Care Plus is a health plan that contracts with both Medicare and South Carolina Healthy Connections Medicaid to provide benefits of both programs to enrollees.

First Choice VIP Care Plus complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.