

**If you would like Preferred Care to share your health information with a family member (like a spouse, or parent or child), a friend, a lawyer or anyone else, you must first give Preferred Care permission to do so.** By filling out and signing this form, you give that permission. Preferred Care may then share your health information with the people whose names you have written in the “Contact” section. Please note:

- There are three (3) boxes on the front of this form that you may check. The **first box** gives Preferred Care permission to share all of your health information, except for HIV/AIDS, psychiatric and substance abuse information. The **second box** gives Preferred Care permission to share HIV/AIDS, psychiatric and substance abuse information, and is explained more fully below. If you check this second box, you must also check the **third box**, and explain the purpose for which you want Preferred Care to share such information.
- Please be sure to write in the Contact’s name and address. Preferred Care will not share your information with a Contact unless the Contact correctly provides the same name and address as you have written. Please note that once Preferred Care gives your health information to a Contact, the Contact may give out that same information without your permission.
- Whether you want to give permission to Preferred Care to share your information is entirely up to you. You do not have to fill out this form in order to enroll with Preferred Care, to be eligible for benefits, to receive medical care, or for Preferred Care to pay your medical claims.
- Please indicate length of time for which your permission is valid. It cannot be longer than two (2) years.
- **You may revoke this authorization at any time.** Gold/GoldAnywhere members, please call Gold Member Services at (585) 327-2480 or toll-free (800) 665-7924. Other plan members, please call (585) 325-3113 or toll-free (800) 950-3224. TTY users call (585) 325-2629, or toll-free (800) 662-1220. You may also cancel this authorization by writing to Member Services, Preferred Care, 220 Alexander Street, Rochester, NY 14607. Please note that a cancellation by telephone must be confirmed in writing. However, your revocation will not affect any use or disclosure that you permitted, and that was made, prior to your revocation.

### **SPECIAL RULES FOR HIV, PSYCHIATRIC AND SUBSTANCE ABUSE INFORMATION**

If you want Preferred Care to share your psychiatric illness or substance abuse information, you must give Preferred Care specific permission. To do so, check the **second box** and write in the particular information you want shared. For example, you might write “mental health records” if you wish Preferred Care to disclose your psychiatric records to a Contact. **Preferred Care will not share this information if you have not specifically authorized it to do so.**

If you wish Preferred Care to share HIV information (which includes any information indicating a person had an HIV related test, has HIV infection, HIV related illness or AIDS, as well as information which could indicate that a person has been potentially exposed to HIV) you must check the **second and third boxes**. Under New York State law, you must also provide the reason why you wish such information disclosed before Preferred Care may share it. You must write that reason (or reasons) in the **line next to the third box**. New York State law holds that HIV related information can only be given to people you allow to have it by signing a written release, or to people who need to know your HIV status in order to provide medical care and services. If you sign this form, HIV related information can be given to the people listed on the form, and for the reason(s) listed on the form. You do not have to sign the form, and you can change your mind and revoke this permission at any time.

*Updated 5.08*



220 Alexander Street, Rochester, NY 14607  
www.preferredcare.org

## Authorization to Disclose Information

Member's Name \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Home Phone \_\_\_\_\_ Member Number \_\_\_\_\_

**I hereby authorize Preferred Care to disclose information to the following contact(s):**

**Contact #1:**

Name \_\_\_\_\_ Relationship to me \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

**Contact #2:**

Name \_\_\_\_\_ Relationship to me \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

**At my request, Preferred Care may discuss past, present or future health care issues with these Contact(s) from \_\_\_\_\_ through \_\_\_\_\_.**  
(start date) (end event/end date; must be within 2 years of start)

**The information that may be disclosed or discussed is:**

- All my information (except HIV, mental health and substance abuse)
- HIV, mental health and substance abuse information (please specify): \_\_\_\_\_
- Purpose of disclosure of HIV information: \_\_\_\_\_

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Mail completed form to:** Preferred Care Member Services, 220 Alexander Street, Rochester, NY, 14607.

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