



## HIPAA RELEASE OF INFORMATION

**PURPOSE:** You can give permission to KelseyCare Advantage to share your personal health information with a person or organization. To do so, please complete and sign this form. This form authorizes information to be released to the individual listed below including plan coverage information, premium amounts and how you pay, referral information, billing, referrals, claims, pharmacy, mailing address and phone number changes and eligibility inquiries.

The person cannot change your plan, make a request for service, appeal or file a grievance for you. The person cannot change your physical address, if you moved. You, your Power of Attorney, guardian or conservator must give us the change.

### KelseyCare Advantage Member Information (this section must be completed)

<b>Member Name</b>		<b>Medicare or Insurance ID #</b>	
<b>Address</b>			
<b>City</b>		<b>St</b>	<b>Zip</b>
<b>Phone Number</b>	<b>Birthdate</b>		<b>Email</b>

### Who Do You Want to Share Your Information With? (this section must be completed)

<b>Representative Name</b>		<b>Relationship to Member/Beneficiary</b>	
<b>Address (optional)</b>			
<b>City</b>		<b>St</b>	<b>Zip</b>
<b>Phone Number</b>			

### Your Permission: (this section must be completed)

I have read and understand this information. I may revoke or change this authorization at any time in writing to KelseyCare Advantage; and the revocation shall be effective except to the extent that KelseyCare Advantage has already used or disclosed information in relation to this Authorization. The Health Insurance Portability and Accountability Act (HIPAA) protects your health information. But we

can't control what happens to your information after we share it with the person or organization you name on this form. At that point, HIPAA or federal privacy laws may not protect your information. It could be shared with others.

By signing this form, I acknowledge that I have read and understand this information. I have a right to receive a copy of this form.

---

**KelseyCare Advantage Member Signature**

---

**Authorized Representative Signature**

I hereby accept the above appointment.

---

**Date**

---

**Date**

### **Duration**

In most cases, permission to share personal health information ends on your last day as a plan member or you write to us and let us know to end it. The effective date is valid from the date signed, unless revoked.

### **Please mail, email or fax the form to:**

#### **Mail:**

KelseyCare Advantage  
P.O. Box 841569  
Pearland, Texas 77584

**Email:** [memberservices@kelseycareadvantage.com](mailto:memberservices@kelseycareadvantage.com)

**Fax:** (713) 442-5450