FirstCarolinaCare Insurance Company
PROTECTED HEALTH INFORMATION AUTHORIZATION

Under federal law, information about your physical or mental health or condition, health care you have received or information about payment for health care you have received, is private and protected. This information is known as "protected health information" or PHI. Generally, FirstCarolinaCare Insurance Company (FCC) cannot release your PHI to third parties, including your relatives or acquaintances, unless you give FCC written permission. If you want a third party to be able to receive PHI from FCC or its business associates (vendors who perform services for FCC involving PHI), please complete the form below.

I, _____, give FCC and its business associates permission to release the following PHI

to the person/entity named below (description of PHI to be released):_____

Name of person/entity allowed to receive PHI: _____

Relationship to Member: _____Telephone Number: _____

Address: _____City: _____ ST: _____ Zip: _____

☐ This permission will expire on: ___/___/____ (initial here) _____ OR

☐ When my FCC enrollment ends. (Initial here) _____ (If no response and/or initial of expiration noted above, this permission will expire 12 months from the date of receipt.)

I understand that I may revoke this permission at any time by giving FCC written notice mailed to the address at the bottom of this form. I also understand that revoking this permission *will not* affect any release of PHI based on this permission before receiving notice. I understand that the protections of the federal law will not apply to any later disclosure of my PHI by the person/entity above. I understand that FCC will not condition treatment or payment of a claim on the Individual's providing authorization for the requested use or disclosure, except that FCC may condition payment of a claim for specified benefits on the provision of an authorization if the disclosure is necessary to determine payment of such claim. I understand that I have the right to inspect or copy the PHI to be used or disclosed. I understand I have the right to refuse to sign this authorization, thereby refusing the authorization to release the PHI.

Please provide the following information to the person granted permission so that we may verify the person's identity and authority to receive your PHI: (1) your Member ID number, (2) your date of birth, (3) your address and (4) the description of the PHI to be released.

Member Name: _____ Employer (if applicable):_____

Member Date of Birth _____/_____/_____ Member ID Number _____

Member Signature: _____ Date: _____

NOTE: If signed by an individual other than the member, describe your authority to act on behalf of the member *(e.g., power of attorney, court order, parent of minor child, etc.)*:_____

Please attach the legal document naming you as the personal representative if not previously submitted to FCC.

This permission will take effect when it has been entered in FCC's operations system, typically five days following receipt by FCC. If you would like this authorization to become effective on a later date, please insert the date here: _____

RETURN THIS COMPLETED FORM TO:
FIRSTCAROLINACARE INSURANCE COMPANY
Attn: Privacy Officer
3310 Fields South Drive, Champaign, IL 61822