ULTIMATE HEALTH PLANS
Good health is where you live.

Permission to Share Information (PSI) Form

Use this form if you want Ultimate Health Plans to share the information we have about you with another person or organization, such as a family member, friend, or other relative; someone who helps take care of you; or a social worker or health-care advocacy group. This form can also be used to allow the specified individual to make changes to the account you have with Ultimate Health Plans.

Important: Please fill out all sections completely and print clearly.

Section 1: Member Name and Contact Information

Permission is given for Ultimate Health Plans and its representatives to share the information listed in **Section 2** about and, if applicable, make changes to the Ultimate Health Plans account of:

Member Last Name:	Member First Name:	Member ID:

Section 2: What Information do you want to be shared?

I am giving Ultimate Health Plans permission to share the information below with the person or organization listed in **Section 3**. Please check the box or boxes that apply.

- ❒ Information about my membership record, including information about eligibility, cost-sharing, and access to benefits
- ❒ Claims information from _____ (month/year) to _____ (month/year)
- ❒ My Protected Health Information (PHI) as described below. Describe in detail the PHI to be disclosed (you can state "any and all" or provide specific information such as the providers, dates of treatment, or type of service that you would like to disclose):

Special kinds of health information have specific laws and rules that have to be followed before it can be disclosed. The special kinds of health information described below are protected under federal and state laws and cannot be disclosed without your written authorization unless otherwise allowed by law. Re-disclosure of this type of information is not allowed except in compliance with federal and state laws or with your written permission. Please read below and check the appropriate box or boxes if you are including permission for us to share any of the following special kinds of health information:

- ❒ HIV and Sexually Transmitted Diseases (STD): To release HIV or STD information, this authorization must include a statement in **Section 2** of the specific HIV or STD information that you are giving permission to release.

- ❒ Alcohol and Drug Treatment: To release alcohol and drug treatment information, this authorization must include a statement in **Section 2** of the specific information that you are giving permission to release, such as "assessment, treatment plan, attendance, discharge plan."

- ❒ Mental Health Treatment: To release mental health treatment information, this authorization must include a statement in **Section 2** of the specific information that you are giving permission to release, such as "assessment, treatment plan, attendance, discharge plan." **Also, disclosure of your therapist's own notes (psychotherapy notes or process notes) needs separate permission. To disclose psychotherapy notes only, please mark the PHI box above and specify the psychotherapy notes you give us permission to share. Please do not mark any other items, or you will have to fill out another request for psychotherapy notes only.**

Section 3: With whom do you want us to share your information?

List the name of ONLY ONE person or organization in this section. You must fill out another PSI form if you want to name more than one person or organization. Ultimate Health Plans may share the information listed in **Section 2** with:

Name of person or organization:			
In care of (name of person in organization to whom mail should be sent):			
Street Address:	City:	State:	Zip:
Telephone Number: ( )			

Section 4: Permission to Change your Account with Ultimate Health Plans

Please tell us if you would like the person or organization listed in **Section 3** to make **changes** to your account information with Ultimate Health Plans.

I am giving Ultimate Health Plans permission to allow the person or organization listed in **Section 3** to make changes to my account information with Ultimate Health Plans. Please check the box or boxes that apply.

- ❒ Membership Record - Phone Number, E-mail Address, Language Preference, Material Format Preference, Mailing Address
- ❒ Primary Care Physician Assignment
- ❒ My account information as described below. Describe in detail the account information you'd like to allow changes to (you can state "any and all" or provide specific information such as phone number only). **Please note that Permanent Addresses can only be changed by legal representatives such as those that hold power of attorney**:

Section 5: Why do you want us to share your information?

Tell us why you want to share the information listed in **Section 2**. If you leave this section blank, we will assume you mean "at my request."

Section 6: End of Permission

The PSI will end 24 months after your signature date unless you specify an end date here: _____

Section 7: Your Signature

I understand the following:

- When the person or organization named in **Section 3** gets this information from Ultimate Health Plans that person or organization may be able to share it with others without my permission. If they do so, federal and state privacy laws may not protect the information.
- I may cancel this permission at any time by sending a letter to Ultimate Health Plans Privacy Officer: PO Box 3459, Spring Hill, FL 34611. If I cancel this permission, Ultimate Health Plans cannot take back any information that it shared when it had my permission to do so.
- If I do not give Ultimate Health Plans permission to share information or allow a specified individual to make changes to my account, or if I cancel my permission to share information or their ability to make changes to my account for the person or organization named in **Section 3,** my Ultimate Health Plans benefits will not be affected in any way.
- In certain circumstances, Ultimate Health Plans may not honor my request to share information.

Print Name of Member:	
Signature of Member or Authorized Representative:	Date:
Printed Name of Authorized Representative if this form is being filled out and signed by someone who has been appointed by the beneficiary or who has power of attorney or health-care proxy:	

Please send this form to: Ultimate Health Plans, PO Box 3459, Spring Hill, FL 34611