UNIVERSITY of MARYLAND HEALTH ADVANTAGE

HIPAA Privacy Consent & Authorization Form

This consent form allows University of Maryland Health Advantage to use and disclose information about me protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This information may be used or disclosed to carry out treatment, payment, or health care operations.

University of Maryland Health Advantage, Inc. has provided me with a Notice of Privacy Practices, which more completely describes uses and disclosures of my protected health information. It provided this notice prior to my signing this form in accordance with my right to review its practices before signing consent.

I understand that the terms of the Notice of Privacy Practices may change and that I may obtain revised notices by either writing to University of Maryland Health Advantage's Compliance Department at its corporate address at 1966 Greenspring Drive, Suite 600, Timonium, Maryland 21093, or by calling University of Maryland Health Advantage's Member Services Department at 1-844-386-6762, 8 AM to 8 PM, 7 days a week from October 1 through February 14 and Monday through Friday from February 15 through September 30. TTY users please call 711.

I understand that I have the right to request – now and in the future – how protected health information is used or disclosed to carry out treatment, payment, and health care operations. I understand that while University of Maryland Health Advantage is not required to agree to my requested restrictions, if it does agree, it is bound by that agreement. I understand that University of Maryland Health Advantage may refuse me services if I refuse to sign this consent.

This also serves as an authorization under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996 [45 CFR § 164.508]. It authorizes University of Maryland Health Advantage, Inc. staff to use and/or disclose my protected health information (PHI) with the individual(s) I have listed below for the purpose(s) of administering my healthcare benefit plan and providing me with Case Management and other services as it deems appropriate. This authorization is valid until such time as I elect to revoke it.

Name(s) & Phone Numbers	Relationship to Member

I understand that I have the right to revoke this consent and authorization at any time provided that I do so in writing, but that University of Maryland Health Advantage and any other entity working directly with University of Maryland Health Advantage for the purposes of carrying out treatment, payment, or health care operations on my behalf may still use information to complete any actions that it began prior to my revoking consent and which rely on my protected health information. I understand that University of Maryland Health Advantage may refuse me further service if I revoke consent.

_____ _____

Signature Date

_____

Printed Name

_____

Member ID Number