Hometown Health Senior Care Plus

HOMETOWN HEALTH RIGHT OF ACCESS FORM

Instructions: Please complete the following information exactly as it appears on your Member Identification Card (ID). Complete the form in its entirety and include as much information as possible. If necessary, call the Member Services Department Number found on your ID card for assistance.

NOTE: THIS FORM DOES NOT NEED TO BE COMPLETED TO SHARE INFORMATION WITH THE LEGAL GUARDIAN OF AN EMANCIPATED MINOR.

Member Full Name _____

Member ID Number _____ Primary Telephone Number _____

Date of Birth _____ Secondary Telephone Number _____

Member Address _____

City _____ State _____ Zip Code _____

I AUTHORIZE Hometown Health/Senior Care Plus, and its affiliates and agents, to disclose information about my health care and/or payment for my health care with the individual listed below:

Name _____ Relationship _____

I DO NOT AUTHORIZE the release of the following types of sensitive information (check boxes that apply):

- ☐ Drug, Alcohol & Substance Abuse Records
- ☐ Communicable Disease Records, including without limitation, HIV/AIDS Records
- ☐ Genetic Testing Records
- ☐ Psychiatric & Mental Health/Behavioral Health Records
- ☐ Other: _____

MEMBER SIGNATURE _____ **DATE** _____

DESIGNATED LEGAL REPRESENTATIVE/GUARDIAN

If this form is signed by a legal representative/guardian on behalf of an individual, please include the following: a copy of a Health Care Power of Attorney, a court order or other documentation establishing custody or other legal documentation demonstrating the authority of the legal representative to act on the individual's behalf.

Legal Representative (print full name) _____

Representative's Relationship to member _____

LEGAL REPRESENTATIVE SIGNATURE _____

DATE _____

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