



# IMPORTANT NOTICE

Dear Subscriber:

If you wish to have Paramount disclose your health information to a third party acting on your behalf such as a spouse, family members, friends, attorney or others, **complete and return the enclosed AUTHORIZATION FORM.** This form must also be completed and returned by any of your **adult dependents** that wish to have you (or someone else) receive their health information/act on their behalf.

Without a signed authorization form, Paramount will be unable to assist third parties with Member Service Inquiries including claims status, payment inquiries, appeals, premium payment inquiries, case management, care coordination and other plan/policy service purposes.

## **Complete these Steps to Grant Authorization:**

- Please complete the enclosed Authorization Form carefully. (Items 1-5 are mandatory)
- Subscribers, Spouses and Dependents (ages 18 and over) must complete, sign, and return their own individual Authorization Form. (Dependent child information can be given to a parent or legal guardian without an Authorization Form.)
- Authorizations will remain in effect until the date of disenrollment from the plan or if the authorization is revoked by you in writing. (see item #6 on the authorization form)

If you have questions, please contact the Member Services department Monday through Friday, between the hours of 8:00 AM and 5:00 PM at 419-887-2525 or 1-800-462-3589. Paramount Care of Michigan can be reached at 734-529-7800 or 1-888-241-5604. Hearing impaired members may contact the TTY at 419-887-2526 or 1-888-740-5670.

Sincerely,

Member Services Department

# PARAMOUNT AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Member Name: \_\_\_\_\_ Member Number: \_\_\_\_\_  
(This should be the name and Paramount ID # of the person whose health information may be used or disclosed.)

Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

- (1) I authorize the use or disclosure of the above-named individual's health information as described below.
- (2) The following individuals or organizations are authorized to make the disclosure:  
Paramount  
1901 Indian Wood Circle  
Maumee, Ohio 43537
- (3) The type and amount of information to be used or disclosed is as follows (check appropriate item(s); please include what specific "other" type of information may be disclosed, if you check the "Other" box:
- All of my personal and health information
  - All claims and billing information only
  - Other (please describe) \_\_\_\_\_

- (4) This information may be disclosed to, and used by the following individuals or organizations:
- Name(s) \_\_\_\_\_
- Address \_\_\_\_\_
- (Include all names and addresses of anyone to whom information may be disclosed.)

- (5) This information is being disclosed for the following purpose(s): \_\_\_\_\_
- Member Service Inquiries
  - Other \_\_\_\_\_

- (6) This authorization shall be in force and effect until the date of disenrollment from the plan, unless earlier revoked or as specified by the following: \_\_\_\_\_

- I understand that the information in my health record may include information relating to sexually transmitted disease, tuberculosis (TB), hepatitis B, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
- I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above could be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
- I understand that I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan or eligibility for benefits.
- I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Paramount. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Signature of Member or Legal Representative \_\_\_\_\_ Date \_\_\_\_\_  
(Signature of the member named at the top of this form, or his/her Legal Representative)

If signed by Legal Representative, relationship to member (attach proof) \_\_\_\_\_

Please keep a copy of this form for yourself.