Wayspring

Consent to Release Confidential Information

MEMBER/PATIENT NAME:____ **Date:**_____/______/ __________

Section 1: What information am I agreeing to share?
This consent to share the following information about me/the Member listed below:

I authorize disclosure of all the health information ("Covered Information Wayspring maintains about me on behalf of Highmark Health Options. This may include treatment information obtained separately from my health care provider(s) and/or Highmark Health Options' claims, case management, care coordination and health care program information. More specifically the health information disclosed could include:

- Medical records
- Pharmacy
- Dental records
- Vision care
- Mental health
- Substance use care
- HIV/AIDS
- Psychotherapy
- Reproductive care
- Infectious disease

Section 2: Who may share this information with Wayspring and Highmark Health Options, on whose behalf Wayspring is acting?
Please select one of the options below:

☐ Option 1: I give permission for all of my past, current, or future treating providers and/or their facilities to disclose my Covered Information to Wayspring.

☐ Option 2: I give permission for these specific individual(s) or organization(s) to share my Covered Information:

Name of the individual(s) and/or healthcare organization(s) that I have (or had) a treating provider relationship:	Enter their contact information:			
	Phone	City	State	ZIP Code

Section 3: To whom may Wayspring disclose my Covered Information, on behalf of Highmark Health Options?
Wayspring may disclose the Covered Information I identified in section 1 to the following Providers for the purpose of providing services to me, including coordinating care and providing treatment:

☐ Option 1: I give permission for all of my past, current, or future treating providers and/or their facilities to receive my Covered Information in connection with Wayspring services.

☐ Option 2: I give permission for these specific individual(s) or organization(s) to receive my Covered Information:

Name of the individual(s) and/or healthcare organization(s) that I have (or had) a treating provider relationship:	Enter their contact information:			
	Phone	City	State	ZIP Code

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Section 4: Friends and Family Members Involved in Your Care

May Wayspring talk any of your friends or family members who are involved in your care about your participation in this program and related services (this may include reference to the Covered Information described in Section 1)?

☐ YES

☐ NO

If you selected "Yes," who may we tell?

Approved family members (include name and phone number): ______________________________

Relationship to Member: ______________________________

Approved individual (include name and phone number): ______________________________

Relationship to Member: ______________________________

Approved individual (include name and phone number): ______________________________

Relationship to Member: ______________________________

Section 5: Community-based Resources

I consent to Wayspring telling the below referenced types of community-based resource organizations about my participation in this program, and related services (this may include reference to Covered Information identified in Section 1, and would come from Wayspring):

☐ Option 1: I authorize disclosure of my Covered Information. This includes these types of community-based resources:

- Housing
- Job placement
- Transportation services
- Food access
- Educational resources
- Support groups

☐ Option 2: I authorize only the disclosure to the following types of community-based resource organizations:

____

Section 6: How to stop the sharing of your information:

I understand that I can terminate or cancel my permission to share my Covered Information at any time by contacting Wayspring as follows:

Wayspring OR compliance@wayspring.com
Attention: Compliance
209 10th Ave S #350
Nashville, TN 37203

When I terminate or cancel this consent, I understand that going forward, my information will no longer be shared. I understand that any information that may have already been shared before Wayspring was notified of my cancellation cannot be taken back.

Section 7: General Terms

This consent expires when I am no longer receiving care from Wayspring or enrolled with Highmark Health Options who is covering Wayspring's services.

____
Date

____
Signature of Member or Member's Legal Representative

____
Signer's Printed Name

If signed by Member's Legal Representative, description of Legal Representative's relationship to Member:

____

Wayspring

HIGHMARK
HEALTH OPTIONS

Discrimination Is Against the Law

Highmark Health Options complies with applicable Federal civil rights laws and regulations and does not discriminate on the basis of race, color, national origin, age, disability, health status, sex, sexual orientation or gender identity. Highmark Health Options does not exclude people or treat them differently because of race, color, national origin, age, disability, health status, sex, sexual orientation or gender identity.

You can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Help in Your Language

Highmark Health Options provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters.
  - Written information in other formats (large print, Braille, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters.
  - Information written in other languages.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, se encuentran disponibles servicios de asistencia con el idioma sin costo alguno para usted. Llame al número que figura al dorso de su tarjeta de identificación (TTY: 711).

Atansyon: Si w pale kreyòl ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele nimewo ki sou do kat idantifikasyon w lan (TTY: 711).

注意：如果您讲中文，可以免费为您提供语言协助服务。拨打您的 卡背面的号码（听障人士专用号码：(TTY: 711）。

注：英語を話す場合は、無料の言語支援サービスを利用できます。 あなたのIDカードの裏面（：711 TTY）の番号を呼び出します。

ધ્યાન આપશો: જો તમે ગુજરાતી બોલતા હોવ તો, તમારા માટે ભાષા સહાયતા સેવાઓ મફતમાં ઉપલબ્ધ છે. તમારા આઇડી કાડડની પાછળ આપેલા નાંબર પર ફોન કરો (TTY: 711).

ATTENTION: Si vous parlez français, des services d'assistance linguistique vous sont offerts gratuitement. Veuillez appeler le numéro qui se trouve au verso de votre carte d'identification (TTY : 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 카드 뒷면의 번호로 전화하십시오 (TTY: 711).

ATTENZIONE: Se parla italiano, per Lei sono disponibili servizi di assistenza linguistica gratuiti. Chiami il numero presente sul retro della Sua carta di identificazione (TTY: 711).

LƯU Ý: Nếu quý vị nói Tiếng Việt, luôn có các dịch vụ hỗ trợ ngôn ngữ được cung cấp miễn phí cho quý vị. Vui lòng gọi số điện thoại trên mặt sau của thẻ nhận dạng của quý vị (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen kostenlose Unterstützung in Ihrer Sprache zur Verfügung. Wählen Sie hierfür bitte die Nummer auf der Rückseite Ihrer Ausweiskarte (TYY: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, may maaari kang kuning mga libreng serbisyo ng tulong sa wika. Tawagan ang numero sa likod ng iyong card (TTY: 711).

कृपया ध्यान दें: यदि आप हिन्दी बोलते हैं, तो भाषा सहायता सेवाएं आपके लिए निशुल्क उपलब्ध हैं। अपने पहचान कार्ड के पीछे दिए गए नंबर पर कॉल करें (TTY: 711)।

توجہ دیں: اگر آپ اردو بولتے/بولتی ہیں تو، آپ کے لیے زبان کی اعانت کی خدمات مفت دستیاب ہیں۔ اپنے آئی ڈی کارڈ کے پیچھے درج نمبروں پر ہمیں کال کریں (ٹی ٹی وائی: 711)-

تنبيه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل على الرقم المدوّن على ظهر بطاقة هويتك (الهاتف النصي: 711).

గమనిక: మీరు తెలుగు మాట్లాడే వారైతే, భాషా సహాయక సేవలు, ఖర్చు లేకుండా, మీరు లభిస్తున్నాయి. మీ ఐడి కార్డుకు (TTY: 711) వెనుక వైపు ఉన్న నంబర్ కి ఫోన్ చేయండి.

Highmark Health Options is an independent licensee of the Blue Cross Blue Shield Association, an association of independent Blue Cross Blue Shield Plans.