MedCare Partners
Health Plan of Texas

Consent to Verbally Disclose Protected Health Information (PHI)

MEMBER NAME:	Member ID:	
DATE OF BIRTH:	Phone #:	
ADDRESS:		
CITY:	STATE:	ZIP CODE:

You have the right to identify family, friends or others involved in your care to verbally receive medical or payment information about you, to help you manage your health care. You may add or change this list at any time. MedCare Partners Health Plan of Texas will only share your health information with the individuals you designate, except as required or permitted by law. This consent form does not authorize releasing copies of patient health records, which requires an Authorization for Use or Disclosure of Patient Health Information form.

I consent for MedCare Partners Health Plan of Texas to verbally disclose the information I have specified below with the following family, friends, or others who are involved in my health care, care coordination, or payment of my health care:

NAME:	RELATIONSHIP:	PHONE NO:
NAME:	RELATIONSHIP:	PHONE NO:
NAME:	RELATIONSHIP:	PHONE NO:

1. **Type of information to be verbally disclosed: (Check all boxes that apply)**

☐ ALL information (including psychiatric consults and mental illness, developmental disabilities, genetic testing, HIV/AIDS and test results, sexually transmitted infection, and/or reproductive care if applicable) excluding substance use disorder information

☐ Health Plan information (billing, benefits, payments authorizations) including updating demographic and other information

☐ Other (describe): _____

2. **I consent to MedCare Partners Health Plan of Texas leaving detailed phone messages at the phone number I provided about my medical and health plan information with the following:**

☐ Voicemail ☐ Person answering (if listed above)

I understand that I have the right to revoke my permission at any time except where MedCare Partners Health Plan of Texas has already made disclosures in reliance upon this request. I understand this consent shall remain in effect until revoked in writing. If an updated CONSENT TO VERBALLY DISCLOSE PROTECTED HEALTH INFORMATION (PHI) form is received and it has an identical family member, friend, or other person listed with updated permissions (different checkboxes), the new version will automatically revoke the previous version on file.

X _____ _____

SIGNATURE OF MEMBER/REPRESENTATIVE DATE

If signed by a personal representative of the member, please print name below and indicate relationship to the member. For Legal Guardian or Power of Attorney, please submit Legal Documentation with this form.

_____

PRINT AUTHORIZED REPRESENTATIVE NAME

_____

RELATIONSHIP TO MEMBER

SUBMISSION

Send this form, and a copy of your representative documentation (if applicable):

MedCare Partners Health Plan of Texas
11602 Bellaire Blvd., Suite C
Houston, TX 77072

You may also fax your request to 1-888-200-3558.

For more information, please contact Member Services at 1-866-627-8901 (TTY users can call 711), 7 days a week from 8 am to 8 pm (except Thanksgiving and Christmas Day) from October 1 – March 31 or Monday through Friday from 8 am to 8 pm (except for Federal holidays) April 1 – September 30.

Consent to Verbally Disclose Protected Health Information (PHI) Information Sheet

How can I give others permission to get verbal information about me?

Complete the Consent to Verbally Disclose Protected Health Information (PHI) form to let us know to whom we may speak about your information. Check the appropriate boxes to indicate what information we may discuss.

How is the information on the form used?

Anytime your designated person(s) call or makes a request on your behalf, we will verify the individual has your permission to receive the information and then we will share the information.

What are some examples of when this form might be useful?

- If a member wants to share information with a spouse or significant other
- If an elderly parent wants an adult child to receive information about treatment, authorization, or payment information
- If an adult child is helping with billing questions
- If a friend is helping a member with health plan questions or issues

Does this mean that you will not speak to anyone I haven't specifically named on this form?

No. If permitted by law, MedCare Partners Health Plan of Texas may speak to other individuals involved in your care (or payment for that care).

What if I change my mind?

You can change or revoke (stop) this permission at any time by writing at MedCare Partners Health Plan of Texas, 11602 Bellaire Blvd., Suite C, Houston, TX 77072 or you can fax to 1-888-200-3558. (NOTE: If an updated Consent to Verbally Disclose Protected Health Information (PHI) form is received and it has an identical family member, friend, or other person listed with updated permissions (different checkboxes), the new version will automatically revoke the previous version on file.

What happens if I don't complete the Consent to Verbally Disclose Protected Health Information (PHI) form?

We will continue to protect your health information as required by law.

Can the person(s) I designate also get copies of my medical information?

No, they can only receive verbal information.