WELLCARE HIPAA RELEASE OF INFORMATION FORM

This form is used to confirm a Member's permission that the Health Plan* may discuss or disclose Protected Health Information (PHI) to a particular person who acts as the Member's Personal Representative. Use of the PHI is strictly limited to that purpose.

Section A – Member Information

By signing this form, I understand and agree that the Health Plan may release my PHI (defined in Section B) to my Personal Representative named in Section C.

Print Name of Member: _____ Date of Birth (mm/dd/yyyy): _____

Address: _____

Telephone Number: _____ Member ID Number: _____

Medicare Number: _____ Medicaid Number: _____

This release does not provide your Personal Representative with any authority to make any treatment or health care decisions. If you want a Health Care Power of Attorney or a Living Will, or you want to appoint a Health Care Proxy, talk to your attorney or your doctor. Also, the Health Plan will not condition benefits payments, enrollment, or eligibility for benefits on the execution of this form.

Section B – Scope of Information

Information Authorized for Use or Disclosure:

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* The Health Plan is WellCare Health Plans, Inc. ("WellCare"). This release applies to each of the following Health Plans: WellCare of Florida, Inc., HealthEase of Florida, Inc., WellCare of New York, Inc., WellCare of Connecticut, Inc., WellCare of Louisiana, Inc., WellCare Health Insurance of Illinois, Inc., WellCare Prescription Insurance, Inc., Harmony Health Plan of Illinois, Inc., Harmony Behavioral Health, Inc., WellCare of Georgia, Inc., WellCare of Ohio, Inc., WellCare Specialty Pharmacy, Inc., WellCare Health Insurance of Arizona, Inc., WellCare of Texas, Inc., WellCare Health Insurance of Illinois, Inc. d/b/a WellCare of Kentucky, Inc., and WellCare Health Plans of New Jersey, Inc.