Tribute Health Plans

Complete Personal and Direct Care

Authorization for Release of Protected Health Information (PHI)

Participant Information:			
First Name:	Last Name:		Middle Initial:
Member ID Number or MBI:	Date of Birth:	Phone Number:	
Arkansas Superior Select, Inc. (offering products under Tribute Health Plans, Complete Personal and Direct Care) can share my health information with the following people or companies:			
Person or Company Name:		Phone Number:	
Address, City, State, ZIP code		Fax Number:	

I give Arkansas Superior Select, Inc. permission to release my health information to the person or company listed above for the purpose described below:

☐ to allow Arkansas Superior Select, Inc. to help me with my benefits and services, OR
☐ to permit Arkansas Superior Select, inc. to use or share my health information for:

I authorize Arkansas Superior Select, Inc. to use or share the following health information:

☐ **All of my health information INCLUDING:**
Genetic information, services or test results; HIV/AIDS data and records; mental health data and records (but not psychotherapy notes); prescription drug/medication data and records; and drug and alcohol data and records (please specify any substance use disorder information that may be disclosed); OR

☐ **All of my health information EXCEPT (check only the boxes below that apply):**
- ☐ Genetic information, services or tests
- ☐ AIDS or HIV data and records
- ☐ Prescription drug/medication records
- ☐ Other:
- ☐ Drug and alcohol data and records
- ☐ Mental health data and records (but not psychotherapy notes)

I authorize the disclosure of my health information to the persons/Company as described above. I understand this authorization is voluntary and made to confirm my directions. I understand that once the information is disclosed, it may be re-disclosed and no longer protected by federal privacy regulations. I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time.

This authorization expires:
☐ When I revoke this authorization ☐ Upon the following date, event or condition*:

My Signature or my Legal Representative's Signature: Date:

_____ _____

Printed Name: _____

If a legal representative signed this form, describe the relationship (parent, legal guardian, Power of Attorney, personal representative, etc.): _____

Mail signed Authorization Form to: Tribute, PO Box 3630, Little Rock, AR 72202