



Authorization to Use and Disclose Health Information

Notice to Member:

- Completing this form will allow Trillium Community Health Plan (Trillium) to (i) use your health information for a particular purpose, and/or (ii) share your health information with the individual or entity that you identify on this form.
- You do not have to sign this form or give permission to use or share your health information. Your services and benefits with Trillium will not change if you do not sign this form.
- If you want to cancel this authorization form, send us a written request to Revoke it at the address on the bottom of this page. A revocation form can be provided to you by calling member services.
- Trillium cannot promise that the person or group you allow us to share your health information with will not share it with someone else.
- Keep a copy of all completed forms that you send to us. We can send you copies if you need them.
- Fill in all the information on this form. When finished, mail it to the address at the bottom of the first page.

MEMBER INFORMATION:

Member Name (print): _____

Member Date of Birth: _____ Member ID Number: _____

I give Trillium permission to use my health information for the purpose identified or to share my health information with the person or group named below. The purpose of the authorization is:

- to allow Trillium to help me with my benefits and services, or
- to permit Trillium to use or share my health information for _____ .

PERSON OR GROUP TO RECEIVE INFORMATION (add additional Persons or Groups on page 2):

Name (person or group): _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: (____) ____ - _____

I AUTHORIZE TRILLIUM 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 all boxes that apply):**
 - Genetic information, services or tests
 - AIDS or HIV data and records
 - Drug and alcohol data and records
 - Mental health data and records (but not psychotherapy notes)
 - Prescription drug/medication data and records

Other: _____

Authorization End Date: / / (date the authorization ends unless cancelled)

Member Signature: _____ **Date:** / /
 (Member or Legal Representative Sign Here)

Relationship to Member: _____

If you are the Member's personal representative, please send us copies of those forms (such as power of attorney or order of guardianship).

ADDITIONAL INDIVIDUAL PERSON(S) OR ENTITY(IES) TO RECEIVE INFORMATION

NOTE: If you are consenting to disclose any substance use disorder records to a recipient that is neither a third party payor nor a health care provider, facility, or program where you receive services from a treating provider, such as a health insurance exchange or a research institution (hereafter, "recipient entity"), you must specify the name of an individual with whom or the entity at which you receive services from a treating provider at that recipient entity, or simply state that your substance use disorder records may be disclosed to your current and future treating providers at that recipient entity.

Name (individual or entity): _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: () - _____

Name (individual or entity): _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: () - _____

Name (individual or entity): _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: () - _____

Name (individual or entity): _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: () - _____

Name (individual or entity): _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: () - _____



Section 1557 Non-Discrimination Language
Notice of Non-Discrimination

Trillium Medicare Advantage complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Trillium Medicare Advantage does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Trillium Medicare Advantage:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Trillium Medicare Advantage's Member Services at: 1-844-867-1156 (HMO SNP) (TTY: 711). From October 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m. From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. A messaging system is used after hours, weekends, and on federal holidays.

If you believe that Trillium Medicare Advantage has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by calling the number above and telling them you need help filing a grievance; Trillium Medicare Advantage's Member Services is available to help you.

You can also 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, DC 20201, 1-800-368-1019 (TDD: 1-800-537-7697).

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



Section 1557 Non-Discrimination Language
Multi-Language Interpreter Services

SPANISH	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-867-1156 (HMO SNP) (TTY: 711).
VIETNAMESE	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-867-1156 (HMO SNP) (TTY: 711).
CHINESE	注意：如果您說中文，您可以免費獲得語言援助服務。請致電 1-844-867-1156 (HMO SNP) (TTY: 711)。
RUSSIAN	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-867-1156 (HMO SNP) (TTY: 711).
KOREAN	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-867-1156 (HMO SNP) (TTY: 711) 번으로 전화해 주십시오.
UKRAINIAN	УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-844-867-1156 (HMO SNP) (TTY: 711).
JAPANESE	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-844-867-1156 (HMO SNP) (TTY: 711) まで、お電話にてご連絡ください。
ARABIC	تنبيه: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال بالرقم 1-844-867-1156 (HMO SNP) (م ك ب ل ا و م ص ل ا ف ت ا ه م ق ر : 711).
ROMANIAN	ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-844-867-1156 (HMO SNP) (TTY: 711).
MON-KHMER CAMBODIAN	ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតល្អប្លង គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-844-867-1156 (HMO SNP) (TTY: 711).
CUSHITE	XIYEEFFANNA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-844-867-1156 (HMO SNP) (TTY: 711).
GERMAN	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-867-1156 (HMO SNP) (TTY: 711).
PERSIAN	توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-844-867-1156 (HMO SNP) (TTY: 711) تماس بگیرید.
FRENCH	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-867-1156 (HMO SNP) (TTY: 711).
THAI	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-844-867-1156 (HMO SNP) (TTY: 711).