Authorization for Sharing Health Information – Part B Addendum

PerformCARE®

Please include any additional recipients that were not included on page 1 and that you would like to include as a recipient of PHI

Part B. Recipient: (person or organization that will receive your PHI)		
The following individual or organization has the right to receive my PHI: Do you want the following individual or organization to also share your PHI with us? ☐ Yes ☐ No		
First name:	Last name:	
Organization Name (if applicable)		
Address:		
City:	State:	ZIP code:
Telephone Number (with area code):		
Relationship to Member in Part A (page 1):		

Part B. Recipient: (person or organization that will receive your PHI)		
The following individual or organization has the right to receive my PHI: Do you want the following individual or organization to also share your PHI with us? ☐ Yes ☐ No		
First name:	Last name:	
Organization Name (if applicable)		
Address:		
City:	State:	ZIP code:
Telephone Number (with area code):		
Relationship to Member in Part A (page 1):		

Part B. Recipient: (person or organization that will receive your PHI)		
The following individual or organization has the right to receive my PHI: Do you want the following individual or organization to also share your PHI with us? ☐ Yes ☐ No		
First name:	Last name:	
Organization Name (if applicable)		
Address:		
City:	State:	ZIP code:
Telephone Number (with area code):		
Relationship to Member in Part A (page 1):		