Authorization to Disclose Protected Health Information

Medica®

1	MEMBER INFORMATION (person who's information will be disclosed)		
	Member name:	Date of birth (MM/DD/YYYY):	
	Street address:		
	City:	State:	ZIP:
	Group/Policy #:	9-digit ID #:	
	Phone number:		

2	AUTHORIZATION		
	I authorize Medica to disclose my health information to the following person listed:		
	Name:	Relationship:	
	Street address:		
	City:	State:	ZIP:
	Phone number:		

3	INFORMATION TO BE DISCLOSED (call your clinic directly if you need to request medical records)
	❍ I authorize disclosure of all medical and pharmacy information, including mental health or substance abuse information, in my file to the person in Section 2 unless otherwise stated in this section. ❍ I authorize only the disclosure of the following information:

4	HEALTH INFORMATION
	The health information is being disclosed at the request of the member or personal representative.

5 STATEMENT

I understand that:

- I may revoke this authorization at any time by writing to Medica Central Health Plan.
- If Medica Central Health Plan has already disclosed health information based on my authorization, my request to revoke will not work for that health information.
- When the health information is disclosed to the third party named in Section 2 above, the information could be re-disclosed by the third party that recieves it and may no longer be protected by federal or state privacy laws.
  Note: Drug and alcohol abuse information may be protected by federal substance abuse confidentiality laws.
- Medica Central Health Plan will not condition treatment, payment, enrollment, or eligibility for benefits depending on whether I sign this authorization form.
- I may keep a copy of this authorization after signing it.
- **This authorization will end one year from the date the form is signed in Section 6.**
- If I would like this authorization to end sooner, I will indicate the specific date or event to end it here:
  ____ /_____ /_____ Event:

6 SIGNATURE

Required of member or personal representative:

- If the member is 18 or older, they must sign this form.
- If signed by a personal representative, also submit a copy of legal authorization (e.g., power of attorney, legal guardian, foster parent).

Signature of member or personal representative:

Signed: _____ Date: _____

Personal representative's relationship to member:

Relationship: _____

Return completed form to:

Medica Central Health Plan
P.O. Box 56099
Madison, WI
53705-9399

Or

Fax : (608) 827-4212