Authorization to Disclose Protected Health Information

Medica

Return completed form to:

Medica Customer Service
Mail Route CP555
PO Box 9310
Minneapolis, MN 55440-9310

Fax: 952-992-3198

1	**MEMBER INFORMATION (person who's information will be disclosed)**		
	Member Name:	Date of Birth (mo/day/year):	
	Street Address:		
	City:	State:	Zip:
	Group/Policy #:	9 Digit ID #:	
	Telephone Number:		

2	**AUTHORIZATION**		
	I am authorizing Medica to disclose my health information to the following person listed:		
	Name:	Relationship:	
	Street Address:		
	City:	State:	Zip
	Telephone 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.
- If Medica 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 Secion 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 will not condition treatment, payment, enrollment, or eligibility for benefits 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 you would like this authorization to end sooner, please indicate the specific date or event:
  ____ /_____ /_____ 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 (for example: power of attorney, legal guardian, foster parent).

Signature of member or personal representative:

Signed: _____ Date: _____

Personal representative's relationship to member:

Relationship: _____