Authorization for Disclosure of Protected Health Information to Requestor

Member Identification

Member Name: ______________________________ Member ID #: ____________

Address: ____

____

Social Security #: ______________________________ Telephone: ____________

Information To Be Released – Covering the Periods of Health Care

From (Date)__________________________ to (Date)__________________________

From (Date)__________________________ to (Date)__________________________

Please check type of information to be released:

☐ Complete billing record	☐ Medical records (or portions of medical records)
☐ Medical claim information	☐ Case Management records
☐ Pharmacy claim information	☐ Grievance/Appeal records

☐ Other information used in payment decision: ______________________________

Purpose of Request

☐ Treatment or consultation	☐ At the request of the member	☐ Billing or claims payment

☐ Other, (specify) ____

Who and Where to Send / Release Information

Name: ____

Address: ____

____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release.

Check One: ☐ **Yes** ☐ **No**

I understand if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment I agree to its release. ***Check One:*** ☐ **Yes** ☐ **No**

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at Mercy Health Plans, 14258 South Outer Forty Road, Suite 300, Chesterfield, MO 63017. Unless revoked, this authorization will expire on the following date or event ______________________________, or 180 days from date of signature, unless otherwise specified.

14528 South Outer Forty Road, Suite 300 Chesterfield, Missouri 63017-5705 314.214.8100 1.800.830.1918 Fax: 314.214.8101
www.mercyhealthplans.com

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The Plan, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Member or Personal Representative Who May Request Disclosure

I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed. **I authorize MHP to use and disclose the protected health information specified above.**

Signature:______________________________________ Date: ________________
Member/Member Representative

Verified by: ____

Return completed original Form to the address below (to be completed by sender):

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