

Authorization to Disclose Protected Health Information To a Designated Representative

1. MCHA Member information (person whose information will be disclosed)

Member Name: _____ Date of Birth: (mo/day/year) ____/____/____

Mailing Address: _____

Group/Policy #: _____ 9 Digit ID #: _____

Telephone Number: _____

2. I am authorizing MCHA to disclose my health information to the following person listed:

Name: _____

Mailing Address: _____

Telephone Number: _____

Relationship: _____

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

5. I understand that:

- I may revoke this authorization at any time by writing to MCHA /Medica.
- If MCHA /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 section 2 above, the information could be re-disclosed by the third party that receives 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.
- MCHA /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 unless I indicate an earlier date or event here: Date ____ / ____ / ____ Or specific 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: _____ Date: _____

Personal representative's relationship to member: _____

Return completed form to:

MCHA /Medica Customer Service, Mail route 0501, PO Box 9310, Minneapolis, MN 55440-9310
Fax # 952-992-3198