

MINNESOTA COMPREHENSIVE HEALTH ASSOCIATION (MCHA)
AUTHORIZATION TO RELEASE INFORMATION

Check here to designate someone else to have access to your protected health information for period of one year and fill in this section. **PLEASE PRINT CLEARLY & SIGN AT THE BOTTOM OF THIS FORM**

MCHA Member/Enrollee (your name): _____

MCHA 5 digit Group #: _____ 9 Digit ID#: _____ Birth Date: _____

List below the name of person(s) you are designating as your authorized member representative:

Address: _____

Relationship to Member/Enrollee: _____

Check here to request specific information about someone else for a specific time span, fill out this section. **PLEASE PRINT CLEARLY & SIGN AT THE BOTTOM OF THIS FORM**

Name of member about whom you are requesting information: _____

Your relationship to the Member/Enrollee: _____ (Mother/Father/etc.)

MCHA 5 Digit Group #: _____ 9 Digit ID#: _____ Birth Date: _____

What are you requesting? Medical Claim History Pharmacy Profile Both Other

If *other*, list what you are requesting: _____

Fill in timeframe for requested information: _____ to _____
Month/Day/Year Month/Day/Year

By signing this form, I authorize MCHA/Medica to release

- medical records, including any mental health or substance abuse records, and
- other pertinent data in my member file, including claims information

to me, or the person(s) designated above who will represent me for the purpose of managing health insurance issues. MCHA/Medica is not responsible for any further disclosure of Protected Health Information made by you or the designated representative named in this authorization. In addition, the Protected Health Information may no longer be protected by state and federal privacy regulations. I understand that I may revoke, in writing, this consent at any time except to the extent that MCHA/Medica has already taken action in reliance on it. Representation will be effective from the date of signature for a period of one year, unless revoked earlier.

SIGNATURE OF MEMBER/ENROLLEE, PARENT OR GUARDIAN

DATE

IF THE MEMBER/ENROLLEE IS 18 OR OLDER, THEY MUST SIGN THE FORM.

Disclosures Pertaining to Substance Abuse Records:

This information has been disclosed to you from records protected by Federal confidentiality rules (42CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.