



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:

Table with 2 columns and 3 rows of checkboxes for information types: Complete billing record, Medical claim information, Pharmacy claim information, Medical records, Case Management records, Grievance/Appeal records.

Other information used in payment decision: _____

Purpose of Request

Table with 3 columns of checkboxes: 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.

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):

