Compass Rose Health Plan | UMR A UnitedHealthcare Company

Authorization for Release of Information

Member information

Member name _____ Health plan member ID# _____

Phone number _____ Date of birth (MM/DD/YYYY) _____

Address _____

City _____ State ___ ZIP _____

I understand that this authorization for release of information is voluntary.

I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164); Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2); and/or, state laws.

I understand that my health information may be subject to redisclosure by the recipient, and that if the organization or person authorized to receive the information is not a health plan or health care provider, the information may no longer be protected by the Federal privacy regulations.

I understand that my health information may contain information created by other persons or entities including health care providers, and may also contain drug and alcohol, mental health, HIV/AIDS, psychotherapy, reproductive and sexually transmitted disease information. I further understand that by signing this document, I am authorizing the release or exchange of this information with the person or organization named below.

I understand that my health plan may not condition (withhold or refuse) treatment, payment, enrollment or eligibility for benefits on whether I sign this form, except for certain eligibility or enrollment determinations prior to my enrollment in its health plan, and for health care that is solely for the purpose of creating Protected Health Information (PHI) for disclosure to a third party.

I understand that I may revoke this authorization at any time by notifying UMR and/or the Compass Rose Health Plan in writing. However, the revocation will not affect any actions UMR and/or the Compass Rose Health Plan and its affiliates took prior to receiving the revocation.

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Authorization for Release of Information (continued)

Designated person information

I authorize UMR and/or the Compass Rose Health Plan and its affiliates to receive from, or disclose, my individually identifiable health information to the following person(s) or organization(s):

Name _____ Phone number _____ Ext. _____

Address _____

City _____ State ___ ZIP _____

Description of individually identifiable health information to be received or disclosed (Check all that apply)

- ☐ All health information
- ☐ Claims
- ☐ Eligibility / Benefits
- ☐ Information used to make benefit determinations
- ☐ Treatment plan(s)
- ☐ Progress reports
- ☐ Attendance only
- ☐ All pertinent information UMR and/or the Compass Rose Health Plan deems appropriate for the purpose(s) checked
- ☐ Other (please describe): _____

Purpose of this authorization (Check all that apply)

- ☐ Benefit management / Decisions
- ☐ Claims administration / Payment
- ☐ Employer mandated treatment referral
- ☐ Administration of worker's compensation claim
- ☐ Administration of a disability claim
- ☐ Subpoena or other legal process
- ☐ To allow the appropriate management of treatment, services, and/or coverage under the member's benefit plan
- ☐ Other (please describe): _____

(Continued)

Authorization for Release of Information (continued)

Dates of records to be disclosed:

Start date (MM/DD/YYYY) _____ End date (MM/DD/YYYY) _____

The member or member's representative must complete the rest of this form.

I understand that this authorization will expire:

- ◯ On this date (MM/DD/YYYY) _____
- ◯ Once the following event occurs: _____

Signature

I have read and understand the above information. (Form must be completed before signing)

Signature of member / legal guardian or member's representative	Name of minor member	Date (DD/MM/YYYY)
Print name of member / legal guardian or member's representative	Relationship to member	Description of representative's authority

In lieu of submitting online or via our Compass Rose Health Plan app, you may submit your form by one of the following methods. If you have any questions, call UMR customer service at 888-438-9135.

Fax:
855-405-2189

Mail:
UMR, P.O. Box 8095
Wausau, WI 54402-2189

Please maintain a copy of this document for your records.

Compass Rose Health Plan

UMR
A UnitedHealthcare Company