Authorization for Release of Information Form

1. Member Information:

Member Name: _____ **Health Plan Member ID#:** _____

Phone Number: _____ **Date of Birth (MM/DD/YYYY):** _____

Address: _____

City: _____ **State:** _____ **Zip code:** _____

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.

2. 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:** _____

Address: _____

City: _____ **State:** _____ **Zip code:** _____

3. 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
- ☐ Other (please describe:) _____

_____

- ☐ Treatment plan(s)
- ☐ Progress reports
- ☐ Attendance only
- ☐ All pertinant information UMR and/or Compass Rose Health Plan deems appropirate for purpose(s) that are checked below

4. The purpose of this authorization is:

(check all that apply)

- ☐ Benefit management and/or decisions
- ☐ Claims administration and/or payment
- ☐ Employer mandated treatment referral
- ☐ Administration of worker's compensation claim
- ☐ Other (please describe): _____

_____

- ☐ Administration of a disability claim
- ☐ Subpoena or other legal process
- ☐ To allow appropriate management of treatment, services, and/or coverage under the member's benefit plan

5. The dates of records to be disclosed:

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

6. Signature

Authorized signature of member or legal guardian/personal representative of member.

I understand that this authorization will expire on this date (MM/DD/YYYY): _____

I understand that this authorization will expire once the following event occurs: _____

A. Member

I have read and understand the above information.

Member signature	Print member name	Date
_____	_____	_____

B. Legal Guardian or Member Representative

I acknowledge that by signing this form I have the legal authority to act on behalf of the member or patient, and am attaching the appropriate documentation to this request.

Guardian/representative signature	Print guardian/representative name	Relationship to member	Date
_____	_____	_____	_____

Mail completed form to: UMR, Customer Service Privacy Unit, P.O. Box 8095, Wausau, WI 54402-8095
Or fax completed form to: (855) 405-2189

Please keep a copy of this document for your records.