CountyCare HEALTH PLAN

Return To: CountyCare Health Plan

P.O. Box 211592
Eagan, MN 55121

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

I. MEMBER: (Name and information of person whose protected health information is being disclosed.)

Name: _____

Address: _____

Member ID #: _____ Date of Birth: _____

II. AUTHORIZATION

I authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary and that I may revoke it at any time by submitting a completed Revocation of Authorization Form to CountyCare. **Failure to answer all questions may result in this request being returned.**

☐ **ADD PERSON TO MY MEMBER PROFILE**

I give CountyCare permission to discuss or disclose my personal and health information with the following person named below. The purpose of this authorization is to help me with my CountyCare benefits and services.

Name of Person authorized to receive PHI: _____ Relationship to Member: _____

Address: _____ Phone: _____

☐ **SPECIFIC RELEASE OF INFORMATION/DOCUMENTS**

I give CountyCare permission to share my information with the following person or group named below.

Person/Organization authorized to receive PHI: _____ Relationship to Member: _____

Address: _____ Phone: _____ Fax: _____

Purpose: Dates of Service: _____

- ☐ Legal
- ☐ Insurance
- ☐ Personal
- ☐ Continuation of Care
- ☐ Other _____

III. DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED

CountyCare can share this Health info:

- ☐ All of my health information; or,
- ☐ All of my health information **EXCEPT:**
  - ☐ Prescription drug/medication information
  - ☐ Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) info
  - ☐ Treatment for alcohol and/or substance abuse information
  - ☐ Behavioral health services or psychiatric care information
- ☐ Other: _____

IV. EXPIRATION

This authorization will expire:

- ☐ One year from the member signed date on this form.
- ☐ Other (insert date or event): _____

V. IMPORTANT INFORMATION ABOUT YOUR RIGHTS

I have read and understood the following statements about my rights:

- ☐ I may revoke this authorization at any time prior to its expiration date by notifying CountyCare in writing, but the revocation will not have any effect on any actions CountyCare, its affiliates took before it received the revocation.
- ☐ I may see and copy the information described on this form if I ask for it.
- ☐ I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).
- ☐ The information that is used and disclosed pursuant to this authorization may be redisclosed by the receiving individual if the individual is not subject to HIPAA privacy requirements.

The member must sign this form to authorize us to release his/her PHI. If the Member cannot sign, only the member's legal representative may sign. If you are the member's legal representative, describe this below and send us copies of those forms (such as power of attorney or order of guardianship). Members 18 years or older must sign the form on their own behalf.

Signature of Member: _____ Date: _____

Signature of Representative (if applicable): _____

Relationship to the Member: _____