Authorization to Use or Release Medical Information

Return to MAHP Attn: Member Services Dept. 1605 Associates Drive Suite 101, Dubuque, IA 52002 Fax: (563) 584-4760

Participant Name _____**Participant Number** _____

Address_____ **Birth Date**_____

Telephone Number (Home) _____ **(Work)** _____

I, the undersigned, authorize and request Health Choices to: ❑ Release to ❑ Obtain from

Person/Organization: _____

Address: _____

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

Phone: _____**Fax:** _____

PURPOSE: Please indicate the purpose for which the information is required (check all that apply):

❑ Further Medical Care ❑ Payment/Billing ❑ Transfer of Care ❑ Personal Use
❑ Legal Use ❑ Treatment Planning ❑ Discussion/Coordination with family members
❑ Appeal/Grievance ❑ Other: _____

INFORMATION CONTENT: Please indicate what information you wish to be released (check all that apply):

❑ Any/all or as much information, written or verbal, as the releasing healthcare provider, in its sole discretion, deems reasonably necessary for the purposes set forth by me for release.
❑ Specific Exclusions_____

COMPLIANCE: In Compliance with state specific statues which require special permission to disclose otherwise privileged information, please indicate if the information being released is pertaining to:

❑ Alcohol and/or Drug Abuse ❑ Developmental Disabilities ❑ Photographs, Video Tapes, Digital Images
❑ Mental Health ❑ Sexually Transmitted Diseases ❑ HIV Related Info (AIDS)
❑ Genetic Testing Information ❑ Other: _____Member's Initials_____

If authorization is given for the disclosure of mental health information, you may inspect the disclosed information at anytime. If you wish to provide authorization to use or disclose psychotherapy notes, you must specifically state so in the box entitled 'Other' above, otherwise those notes will not be used or disclosed.

You may refuse to sign this authorization. Refusal to sign, will not affect your ability to obtain treatment or payment or your eligibility for benefits. You may revoke the authorization in writing at any time except to the extent that Health Choices has already acted in reliance upon the Authorization. To revoke this Authorization, send a written request to: **MAHP Privacy Officer, 1605 Associates Drive, Suite 101, Dubuque, IA 52002**

If the person or entity that receives the information under this Authorization is not a health care provider or health plan covered by Federal privacy regulations, the information may be redisclosed and no longer protected by Federal law. However, Wisconsin law strictly limits redisclosure of information about HIV. You are entitled to receive a copy of this authorization form.

This Authorization shall become effective immediately upon signature and shall remain in effect for 24 months from the date of signature or if necessary, the intended date of _____.

_____ _____
Signature of Participant or Participant's Representative Date

If signed by other than member, indicate all that apply:

❑ Custodial Parent ❑ Minor ❑ Disabled ❑ Deceased ❑ Authorized Legal Representative
❑ Legal Guardian ❑ Incompetent ❑ Executor of Estate ❑ Power of Attorney for Healthcare (POA Enclosed)