



Authorization to Use or Disclose Medical Information

Member Information	Member Name				Previous last name (if any)	
	Street Address				Date of Birth	
	City	State	ZIP code	Member ID#:	Phone number	
Who has the information for release?	Hospital / Clinic / Physician / Health Plan			Phone number	Fax number	
	Street Address			City	State	Zip code
To whom should the information be disclosed?	Family Member / Hospital / Clinic / Health Plan			Phone number	Fax number	
	Street Address			City	State	Zip Code
Information to be sent	<input type="checkbox"/> Entire Medical Record <input type="checkbox"/> Case Management and/or Medical Authorization		<input type="checkbox"/> Claims & Billing Information <input type="checkbox"/> FSA / HRA Information <input type="checkbox"/> Grievance & Appeals Information		<input type="checkbox"/> Membership Information <input type="checkbox"/> Other, please specify:	
Special Permissions	<input type="checkbox"/> Developmental Disabilities <input type="checkbox"/> Genetic Testing Information <input type="checkbox"/> HIV-Related Information (AIDS)		<input type="checkbox"/> Mental Health Information <input type="checkbox"/> Psychotherapy Notes*		<input type="checkbox"/> Sexually Transmitted Diseases <input type="checkbox"/> Substance Use Disorders (alcohol and/or drug abuse)	
Limitations of Release	Do <u>NOT</u> release the following: (leave blank if no special limitations)					
Purpose	<input type="checkbox"/> Grievance & Appeals <input type="checkbox"/> Discussion / Care Coordination <input type="checkbox"/> Further Medical Care <input type="checkbox"/> Legal Use		<input type="checkbox"/> Payment / Billing <input type="checkbox"/> Personal Use <input type="checkbox"/> Treatment Planning <input type="checkbox"/> Transfer of Care		<input type="checkbox"/> Other, please indicate:	
Release Method	<input type="checkbox"/> Mail	<input type="checkbox"/> Fax	<input type="checkbox"/> Phone	<input type="checkbox"/> Email ➤ Email Address:	<input type="checkbox"/> Pick Up ➤ Date: / /	
Authorization and Revocation	<ul style="list-style-type: none"> I voluntarily authorize the disclosure of the protected health information identified above. I understand that I may refuse to sign this authorization. Refusal to sign will not affect my ability to obtain treatment or payment for services, nor will it impact my eligibility for benefits. I understand that I may revoke this authorization at any time, except to the extent disclosure of records has already occurred in reliance on it. I understand my revocation must be in writing and will not take effect until received. <i>Send your written request to: Privacy Officer, 1605 Associates Dr., Suite 101, Dubuque, IA 52002.</i> I understand that if the person or organization that receives my protected health information is not a health plan or health care provider, the released information may no longer be protected by privacy regulations. I understand that this authorization is effective immediately upon signature and will remain in effect for 24 months from the date of signature, unless I specify an earlier end date here: ____/____/____ 					
	Signature of Member or Member's Representative				Relationship to Member	
	Printed Name				Date:	

Instructions to complete the Authorization to Use or Disclose Medical Information Form.

Print legibly and include all pertinent information.

1. **Member Information.** Complete the entire section.
2. **Who has the information for release?**
 - This authorization will be sent or provided to the facility listed in this section.
 - If requesting that Health Choices disclose protected health information, see address below.
 - If requesting that records be released to Health Choices from another organization, include as much information as possible.
3. **To whom should the information be disclosed?** Provide pertinent details for the recipient of your protected health information. If the information is to be disclosed to a family member, please specify in this section.
4. **Information to be sent.**
 - In this section, check all the boxes that apply to your specific need.
 - Release of “FSA/HRA information” would be information pertaining to a Flexible Spending Account or a Health Reimbursement Arrangement.
 - If you check the “other” box, please tell us in detail the information that is needed to meet your specific needs. If you are requesting information pertaining to a specific date of service or a specific medical condition or diagnosis, please use this box to identify those specific needs as well.
5. **Special Permissions.**
 - In accordance with federal and/or state laws, special permission is required for disclosure if the release pertains to any of the categories listed within this section. Identify and authorize the release of this information by selecting the boxes that apply to your specific need. **Note that if authorization is for the release of psychotherapy notes, this authorization cannot be combined with another release.*
 - If authorization is for the disclosure of mental health information, you may inspect the disclosed information at any time.
 - Certain laws may prohibit re-disclosure of protected health information, such as state laws pertaining to mental health information and developmental disabilities.
 - Federal regulation at 42 CFR Part 2 prohibits unauthorized disclosure of substance abuse records. Federal rules prohibit any further disclosure of this information unless further disclosure of this information is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rule restricts any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
6. **Limitations of Release.** If you would like to place any limitations on this authorization for disclosure of protected health information, specify your limitations here. Please leave blank if there are no special limitations on the information for disclosure.
7. **Purpose.** Indicate the purpose for which the information is required.
8. **Release method.** Tell us how you would like your information delivered.
 - Mail option. Records will be mailed to the address listed under “To whom should the information be disclosed?”.
 - Fax option. Records will be faxed to the fax number listed under “To whom should the information be disclosed?”.
 - Phone option. Information selected under “Information to be sent” will be released over the phone to the individual listed under “To whom should the information be disclosed?”.
 - Email option. Records will be emailed to the email address indicated in this field.
 - Pick up option.
 - Please indicate the date in which you will be picking up the records.
 - Upon receiving the records, a photo I.D. will be required.
 - If someone other than the patient will be picking the records up, please indicate on this form, the person’s name.
9. **Authorization and Revocation.** Sign and Date the authorization form.
 - You are entitled to receive a copy of this Authorization form.
 - Verification of the authority of a personal representative, such as a copy of a power of attorney or health care power of attorney, will be required, if it has not been provided already.

10. Return to:

Health Choices
1605 Associates Drive, Suite 101
Dubuque, IA 52002

Fax: (563) 584-4760
Email: healthchoices@mahealthcare.com