

MercyCare Health Plans
Authorization for Use & Disclosure of Protected Health Information

Member:

Name of Individual/previous name

Birth Date

Street Address

City, State, ZIP, Phone

Authorizes:

Disclosure of Protected Health Info. To:

MercyCare Insurance Co.
PO Box 550
580 N. Washington St.
Janesville, WI 53547-0550

Individual/agency/organization receiving information

Street Address

City, State, Zip Code

INFORMATION TO BE USED OR DISCLOSED:

- | | | |
|--|---|--|
| <input type="checkbox"/> Medical Claims history | <input type="checkbox"/> Medical Management | <input type="checkbox"/> Enrollment |
| <input type="checkbox"/> Prescription Claims history | <input type="checkbox"/> Customer Service | <input type="checkbox"/> Premium Billing |

Or, the following is a specific description of the protected health information I authorize to be used and or disclosed

In compliance with WI Statutes, which require special permission to release otherwise privileged information, please release records pertaining to: [check all that apply - items not checked will not be released.]

- Mental Health Developmental Disabilities Alcohol &/or Drug Abuse HIV Test Results

Other (specify): _____

For the following dates: From: _____ To: _____

PURPOSE FOR NEED OF DISCLOSURE: (check applicable categories)

- Further Medical Care Coordinating Care for Dependent/Spouse Insurance Eligibility/Benefits
 Claims Resolution

Other (specify) _____

Initials

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Receive copy of this authorization – I understand that if I sign this authorization, I have the right to request a copy of this authorization.

Right to Refuse to sign this authorization – I understand that I am under no obligation to sign this form.

Right to Withdraw this authorization – I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to MercyCare Customer Service Department. I am aware that my withdrawal will not be effective until received by MercyCare, and will not be effective regarding the uses and/or disclosures of my health information that MercyCare has made prior to receipt of my withdrawal statement. I understand if the authorization was obtained as a condition of obtaining insurance coverage, other law provides MercyCare with the right to contest a claim under the policy or the policy itself.

Marketing – I understand if MercyCare uses this authorization for marketing activities, I will be informed if they receive any direct or indirect payment in connection with the use or disclosure of my information.

Right to Inspect or Copy the Health Information to be used or disclosed – I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting MercyCare Customer Service Department.

HIV Test Results – I understand my HIV test results may be released without authorization to persons/organizations that have access under State law and a list of those persons/organizations is available upon request.

REDISCLASURE NOTICE: I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

EXPIRATION DATE: This authorization is good until (indicate date or event) _____.
By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE OF MEMBER/LEGAL REP: _____ **DATE:** _____

(if signed by other than individual, state relationship) _____



MERCYCARE USE ONLY.	
Date request received:	_____
Extension requested:	____ Yes ____ No
If yes, give reason:	_____ _____
Member notified in writing on this date:	_____
Date PHI sent to requestor:	_____
Staff member processing request:	_____ Date: _____
Privacy officer verification:	_____ Date: _____