

Authorization for Release of Personal and Health Information

Member Name _____

Identification Number _____

Member Date of Birth _____

I request and authorize UPHP or its subsidiaries to release my personal and health information, which may include:

- a. claims and billing information.
- b. medical records created by medical practitioners that UPHP received, including records regarding general medical care, alcohol and drug-abuse treatment, psychological or psychiatric treatment, social services counseling, human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) or AIDS-related complex (ARC), communicable diseases or infections, venereal diseases, tuberculosis, and hepatitis.
- c. member information.
- d. transportation requests.

This information does not include psychotherapy notes recorded by a mental-health profession during a counseling session.

2. Release information to:

Name: _____

Address: _____

Relationship to member: _____

Telephone number: _____

City, State, Zip: _____

3. This authorization expires (choose one):

one year from the date when it is signed.

on the following date: _____

4. I understand that I have the right to receive a copy of this authorization after it is signed.

5. I understand that the persons to whom information is released under this authorization may possibly re-release the information to others without my knowledge or consent as described in the UPHP *Member Handbook*.

6. I understand that I may revoke this authorization at any time, but I must do so in writing to UPHP at the following address:

Upper Peninsula Health Plan
228 W. Washington Street
Marquette, MI 49855

7. By signing this authorization, I understand that this will in no way affect base treatment, payment, enrollment, or eligibility for benefits through UPHP.

Signature

Date Signed

If signed by a person other than the member, please state the relationship and authority to do so (**proof of relationship must be attached and returned with this signed authorization**):

Parent of minor child

Power of attorney

Legal guardian

Personal representative of member

VERIFICATION:

UPHP has verified the identity of the member's representative by reviewing the attached document (e.g., driver's license, power of attorney, order appointing guardian, order appointing personal representative of the member, etc.) and he or she is authorized to act in that capacity on the behalf of the member.

Signature of UPHP Staff Member

Date Signed