UPHP
UPPER PENINSULA HEALTH PLAN

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

You may let the Upper Peninsula Health Plan (UPHP) share your protected health information with someone else. This could be a relative, friend or lawyer. If you fill out and sign this form, you let that person(s) have access to your health information. This may include member information, claims and billing information and/or medical records sent to UPHP.

Member Information:

Name:_____ Member ID Number:_____

Date of Birth:_____ Phone Number:_____

Street Address:_____

City, State, Zip:_____

Authorized Party:
The Upper Peninsula Health Plan may share my health information with the following person or organization:

Name of Person/Organization:_____

Relationship:_____

Street Address:_____

City, State, Zip:_____

Phone Number:_____ Fax Number:_____

Purpose of the Authorization:

☐ At my request

OR

☐ For the following purpose:_____

Information to be disclosed:
I authorize my plan to disclose my protected health information as follows. I understand this information may include, when applicable, information relating to sexually transmitted disease, Human Immunodeficiency Virus, and any other communicable disease. It may also include information about behavioral or mental health services, and referral and/or treatment for alcohol and drug use.

☐ All clinical, claims, medical records, billing, benefit or coverage information

OR

☐ Specific information only. List the amount or type of information to be shared:

_____

_____

Expiration: Unless an earlier expiration date is given, this authorization will expire one year from the signature date.

☐ Authorization should end on ____ / ____ / ____
OR
☐ Upon the following event: _____

Member Rights:
I am aware that:

- My consent is voluntary and made at my request.
- I have the right to get a copy of this form.
- The released information may no longer be protected by federal regulations once it has been released and may be redisclosed by the person/organization listed identified above.
- Information that has already been shared based on this authorization cannot be taken back.
- I may cancel my authorization at any time, but I must do so by submitting a written request to UPHP.
- This authorization will not affect my treatment, payment, enrollment, or eligibility for benefits.

Signature:
I have read and reviewed this form. By signing this form, I authorize UPHP to release my PHI to the person(s) named. I approve the use and/or release of my PHI as described above.

Signature:_____ Date:_____

If the person who signs this form is not the member, check the box below that best describes your connection to the member. Legal proof must be returned with this form if not already on file.

☐ Parent ☐ Legal Guardian ☐ Power of Attorney ☐ Personal Representative ☐ Other

OFFICE USE ONLY:
UPHP has reviewed and approved the attached document (power of attorney, order appointing guardian, order appointing personal representative, etc.).

Signature of UPHP staff:_____ Date:_____

This authorization was revoked
Note: This section may be completed by sending a copy of this completed form to the beneficiary/authorized representative for signature or may be completed by a UPHP Staff member upon receipt of a written request from the beneficiary/authorized representative.

Signature of Individual:_____ Date:_____

Signature of UPHP staff:_____ Date:_____
Supporting Notes: