Authorization to Disclose Protected Health Information (PHI)

You can let Upper Peninsula Health Plan (UPHP) share your PHI with someone. This could be a relative, friend or lawyer. If you complete and sign this form, you let that person(s) access your health information. This may include claims and billing information and medical records sent to UPHP.

Member Information		
Name (last, first, middle initial):		
Member ID Number:	Date of Birth:	Phone Number:

Authorized Party - UPHP may share my PHI with the following person or organization:		
Name of Person/Organization:		
Street:		
City:	State:	Zip:
Phone Number:	Fax Number:	

Purposes of the Authorization

☐ At my request **-OR-** ☐ For the following purpose: _____

Information to be disclosed:
I authorize UPHP to disclose my PHI as follows (**please check only one box**). I understand this information may include, when applicable, information relating to sexually transmitted diseases, 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.

☐ Full disclosure: All clinical, claims, medical records, billing, benefit or coverage information.
☐ Specific information only. List the amount or type of information to be shared:

_____

_____

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 identified above.
- Information that has already been shared based on this authorization cannot be taken back.
- I may cancel my authorization at any time by submitting a written request to UPHP.
- This authorization will not affect my treatment, payment, enrollment, or eligibility for benefits.

- CONTINUED ON BACK SIDE

Expiration: Unless an earlier expiration date is given, this authorization will expire **when my UPHP coverage ends.**

☐ Authorization should end on: _____/_____/_____

Signature:
By signing this form, I authorize UPHP to release my PHI to the person/organization 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 relationship with the member. Legal proof must be returned with this form if not already on file.

☐ Parent ☐ Legal Guardian ☐ Power of Attorney ☐ Other _____

OFFICE USE ONLY:

UPHP has reviewed and approved.

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 and/or authorized representative.

Signature of Individual: _____ Date: _____

Signature of UPHP Staff: _____ Date: _____

Supporting Notes:

Return completed and signed form via fax to (906) 225-7690 or via mail to:
853 W. Washington Street, Marquette, MI 49855

Upper Peninsula Health Plan (UPHP) MI Health Link (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Michigan Medicaid to provide benefits of both programs to enrollees.

If you have questions, you can contact your Care Coordinator or call UPHP Customer Service at 1-877-349-9324 (TTY: 711), Monday through Friday from 8 a.m. to 9 p.m. Eastern Time. The call is free.

You can get this document free of charge in other formats, such as large print, braille, or audio call 1-877-349-9324 (TTY: 711) Monday through Friday from 8 a.m. to 9 p.m. Eastern Time. The call is free.