Authorization to Disclose Protected Health Information (PHI)

You can let Upper Peninsula Health Plan (UPHP) share your PHI with someone else. This could be a relative, friend or lawyer. If you complete 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 (last, first, middle initial):		
Member ID Number:	Date of Birth:	Phone Number:
Street:		
City:	State:	Zip:

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:	
Relationship: ☐ Spouse ☐ Sibling ☐ Parent ☐ Child ☐ Agent/Broker ☐ Friend ☐ Other		

Purposes of the Authorization

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

Information to be disclosed:
I authorize UPHP to disclose my protected health information 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:

_____
_____
_____

- CONTINUED ON BACK SIDE -

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

☐ Authorization should end on: _____/_____/_____

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/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 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 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