

## MedicareBlue Rx Authorization to Release Information

If you would like MedicareBlue Rx to release your protected health information to a person or organization on your behalf, such as a family member, friend, or employer/former employer, you need to fill out and sign the enclosed Authorization form. Please review and fill out the entire form. If you have any questions, please contact the member services department number listed on the back of your member identification card.

- **Section A: Individual Whose Information will be Disclosed:** Include your Name, Address, and Member Identification Number (Telephone number is optional, but may make any follow-up communications with you easier);
- **Section B.1: Purpose of this Authorization:** If this authorization is for disclosures to a person or organization on your behalf, such as a family member, friend, or employer/former employer, check the “At your request” box. This is also the appropriate box for other uses and disclosures you request. For authorizations another person requests, check the second box and explain the purpose of allowing the use or disclosure.
- **Section B.2: Protected Health Information to be Disclosed:** You may check one or both boxes. If you check the second box, please describe the types of your protected health information you are allowing to be disclosed.
- **Section B.3: Persons or Organizations Authorized to Receive and Use:** Identify the persons or organizations who may receive and use your protected health information. If you want MedicareBlue Rx to disclose your protected health information to a person or organization on your behalf, such as a family member, friend, or employer/former employer, write the name(s) and address(es) of the person(s) or organization(s) here.
- **Section B.4: Entities Authorized to Disclose:** You may check one or both boxes. You must check the “MedicareBlue Rx” box if you want MedicareBlue Rx to disclose your protected health information on your behalf, such as to a family member, friend, or employer/former employer. If you check the second box, please list other persons or organizations who you are allowing to disclose your information.
- **Section C: Expiration and Revocation:** You must include an expiration date or occurrence. For Minnesota residents, that date cannot be more than one-year from the date you sign the form. For Montana residents, the date cannot be more than two-years from the date you sign the form.
- **Signature:** Sign and return the completed authorization form to the following address:

MedicareBlue Rx  
1020 Discovery Road,  
Ste 100, Eagan, MN 55121  
Fax 1-651-286-4400

- **Personal Representative:** A Personal Representative is a person with authority under state law to make health care decisions on behalf of an individual. MedicareBlue Rx will need documentation of that legal status to process an authorization signed by a Personal Representative.