Authorization to Release Information

Use this form when you want 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.

Questions?

Call Customer Service at 1-888-832-0075, 8 a.m. to 8 p.m., daily, Central and Mountain Time. TTY/TDD users should call 1-800-693-3819.

AUTHORIZATION TO RELEASE INFORMATION

Section A: Individual Whose Information Will be Disclosed

Name: ____

Address: ____

Telephone: ____________________ Member Identification Number: ______________

Please read the following and complete the information requested.

No Conditions: This authorization is voluntary. We will not condition your enrollment in a health plan or eligibility or payment for benefits on receiving this authorization.

Effect of Granting this Authorization: The protected health information described below may be disclosed to and/or received by persons or organizations who are not subject to federal health information privacy laws. These persons or organizations may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws.

Psychotherapy Notes: This authorization is not for psychotherapy notes.

Section B: The Use and Disclosure Being Authorized

1. **Purpose of this Authorization:** (Check one box and fill in the blank, if applicable.)

☐ At your request (or the request of your personal representative).

☐ For the following purposes: ____

____

2. **Protected Health Information to be Disclosed:** I SPECIFICALLY AUTHORIZE the release of confidential information relating to substance abuse, mental health and HIV/AIDS, consistent with the description below. Specifically and meaningfully describe your protected health information that you are allowing to be disclosed (check at least one box and fill in the blank, if applicable):

☐ Information necessary to help me understand my benefits and resolve billing issues, benefits disputes, and other matters.

☐ The following information and types of information: ______________________________

____

____

3. **Persons or Organizations Authorized to Receive and Use:** Name or specifically identify the persons and/or organizations (or the classes of persons and/or organizations) whom you are allowing to receive and use the protected health information that you described above:

______________________________ ______________________________

Name or Title within Organization   Phone Number

____

Address (Street, City, State, ZIP code)

4. **Entities Authorized to Disclose:** Name or specifically describe the persons and/or organizations (or the classes of persons and/or organizations) who you are allowing to disclose the protected health information that you described above (check at least one box and fill in the blank, if applicable):

☐ MedicareBlue Rx

☐ Other persons/organizations: ____

____

Section C: Expiration and Revocation

Expiration: This authorization will expire (check a box and complete the blanks, as applicable):

☐ On (insert date) _____ / _____ / _____

☐ When a particular matter is resolved (specify the matter, for example, "Claim for February 2006 prescriptions"): ____

☐ When my MedicareBlue Rx coverage is terminated.

For Minnesota residents: This authorization may not last longer than one year.
For Montana residents: This authorization may not last longer than two years.

Right to Revoke: You may revoke this authorization at any time by giving written notice of revocation to the address listed below. Revocation of this authorization will not affect any action we took in reliance on this authorization before we received your written notice of revocation.

Mailing address: MedicareBlue Rx
Attention: Privacy Officer
P.O. Box 64813
St. Paul, MN 55164

Signature

I, ______________________________________, have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization for the use and/or disclosure of my protected health information, as described in this form.

Signature: ________________________________ Date: ______________________

If this authorization is signed by an authorized representative, complete the following:

Authorized Representative's Name:

____

Relationship to Individual: ____
(An Authorized Representative must provide documentation of legal status, such as Power of Attorney.)

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION

MedicareBlue Rx Authorization to Release Information Instructions

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 this Authorization to Release Information form. Please review and fill out the entire form. If you have any questions, please contact Customer Service at 1-888-832-0075, 8 a.m. to 8 p.m., daily, Central and Mountain Time. TTY/TDD users should call 1-800-693-3819.

- **Section A: Individual Whose Information Will Be Disclosed:** Include your name, address and member identification number. Your 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 "For the following purposes:" 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 person or organization 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, phone number and address of the person or organization 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
  Attention: Privacy Officer
  P.O. Box 64813
  St. Paul, MN 55164
  Fax: 1-651-286-4400

- **Authorized Representative:** An Authorized 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 an Authorized Representative.