



Instructions

If you need assistance in completing this form, please contact MCHCP at 800-487-0771. Please fill out this form completely to ensure your authorization is valid.

Section 1: Member Information

Name (Last, First, MI): New Name _____

Address: New Address _____

City: _____ **State:** _____ **Zip Code:** _____

MCHCP ID: _____

OR _____

Social Security Number: _____

Primary Phone: Home Work Cell
 () - _____

Secondary Phone: Home Work Cell
 () - _____

Section 2: Information Disclosure

I authorize the MCHCP to use and/or disclose my protected health information to the person(s) designated below: **Name** (Last,

First, Middle Initial):	Complete Address (Street, City, State, & Zip Code):	Relationship to Member:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Section 3: Information Usage **Section 4: Specific Information to be Disclosed**

I authorize the release of my health record from (select one):

____ / ____ / ____ to ____ / ____ / ____ (MM/DD/YYYY)

All past, present, and future periods

Expiration Date: This authorization is valid (select one):

Until ____ / ____ / ____ (MM/DD/YYYY)

As long as I am a member of MCHCP Until a

specific event _____

If no expiration time period is given, the authorization is valid for one year.

I authorize the release of:

My complete health record (INCLUDING records relating to mental health care, communicable diseases including HIV or AIDS, and alcohol/drug abuse treatment)

OR (select all that apply):

My complete health record (EXCEPT records relating to mental health care, communicable diseases including HIV or AIDS, and alcohol/drug abuse treatment)

Mental health records

Communicable diseases, including HIV and AIDS

Alcohol/drug abuse treatment

Other (please specify): _____

Section 5: Purpose of Disclosure Request

The health record is to be disclosed for the following purpose (please select one):

At my request or the request of my legal representative Other

(specify): _____

Section 6: Subscriber Authorization

I have had an opportunity to review and understand the content of this authorization form. By completing this form, I understand that I am allowing MCHCP to share my protected health information with the person(s) named above. I understand that I have the right to revoke this authorization at any time provided that I do so in writing, except to the extent that MCHCP has already used or disclosed my information based on this authorization as described in MCHCP's Notice of Privacy Practices. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be redisclosed by the recipient and may no longer be protected by federal or state law. Note: If a guardian, legal representative or a personal representative signs this document s/he must provide separate documentation of his/her authority to act for the individual.

Signature of Member: _____ **Date (MM/DD/YYYY):** ____ / ____ / ____

Or, Signature of Person Authorized by Law to Act for the Member (Attach proof of authority to act): _____ **Date (MM/DD/YYYY):** ____ / ____ / ____