Authorization to Disclose Protected Member and Health Information

Member name: ____
Address: ____
Member ID number: ____

This form is used to ask HealthPartners to give out member and health information:

1. Who may give it out: HealthPartners, 8170 33rd Avenue South, Bloomington, MN 55425.
Mailing address: Mail Stop 21104G, P.O. Box 1309, Minneapolis, MN 55440-1309
2. Who may get and use it: *(Please print name, address, phone number and relationship – for example: spouse, adult child, parent, foster parent, stepparent, sibling, attorney, employer, domestic partner, guardian, other.)*

Name	*Address, City, State, Zip*	*Phone #*	*Relationship*

3. What information may be given out: *(Call your clinic directly to request medical records.)*
   - ☐ Membership information (for example: date of coverage)
   - ☐ Claims/authorization information (for example: payments made)
   - ☐ Medical management information (for example: authorizations, case management)
   - ☐ FSA/HRA information (for example: claims, remaining balances)
   - ☐ Other (as described here): ____

4. How long this permission lasts: This authorization is valid for one year (12 months) after the date it is signed, unless an earlier expiration date is requested here: ____ / ____ / ________ (MM / DD/ YYYY).

I understand that:

- Unless specifically permitted by law, this permission does not last more than one year.
- I may revoke this permission at any time by writing to HealthPartners at the address in #1.
- Revoking my permission does not apply to information that has already been given out.
- An electronic or photocopy version of this form is as valid as the original.
- I have the right to see or copy health information to be given out.
- If this information goes to a health care provider or a health plan covered by federal privacy laws, it is protected by those laws.
- Information that goes to other persons or entities may not be protected by federal privacy laws. It may be given out again. Note: drug and alcohol abuse information may be protected by federal substance abuse confidentiality laws.
- I do not have to sign this form. If I do not sign this form, HealthPartners cannot give out the information that I have asked to be released (above). HealthPartners cannot condition treatment, payment, eligibility or enrollment on my signing this form.

______________________________ ______________________
Signature of member or member's representative *Date*

If signed by a member's representative, also submit a copy of legal authorization (for example: power of attorney, guardian, foster parent, retainer). ☐ I would like a copy of this form sent to the member.

______________________________ ______________________
Print representative's name *Relationship to member*

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Please complete and sign this form. Mail it back to HealthPartners, Mail Stop 21104G, P.O. Box 1309, Minneapolis, MN 55440-1309.