MercyCare Health Plans
Authorization for Use & Disclosure of Protected Health Information

Member:

_____ _____
Name of Individual/previous name Birth Date

_____ _____
Street Address City, State, ZIP, Phone

Authorizes:

MercyCare Insurance Co.
PO Box 550
580 N. Washington St.
Janesville, WI 53547-0550

Disclosure of Protected Health Info. To:

_____
Individual/agency/organization receiving information

_____
Street Address

_____
City, State, Zip Code

INFORMATION TO BE USED OR DISCLOSED:

☐ Medical Claims history ☐ Medical Management ☐ Enrollment
☐ Prescription Claims history ☐ Customer Service ☐ Premium Billing

Or, the following is a specific description of the protected health information I authorize to be used and or disclosed

In compliance with WI Statutes, which require special permission to release otherwise privileged information, please release records pertaining to: [check all that apply - items not checked will not be released.]

☐ Mental Health ☐ Developmental Disabilities ☐ Alcohol &/or Drug Abuse ☐ HIV Test Results

Other (specify): _____

For the following dates: From: _____ To: _____

PURPOSE FOR NEED OF DISCLOSURE: (check applicable categories)

☐ Further Medical Care ☐ Coordinating Care for Dependent/Spouse ☐ Insurance Eligibility/Benefits
☐ Claims Resolution

Other (specify) _____

_____
Initials

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Receive copy of this authorization – I understand that if I sign this authorization, I have the right to request a copy of this authorization.
Right to Refuse to sign this authorization – I understand that I am under no obligation to sign this form.
Right to Withdraw this authorization – I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to MercyCare Customer Service Department. I am aware that my withdrawal will not be effective until received by MercyCare, and will not be effective regarding the uses and/or disclosures of my health information that MercyCare has made prior to receipt of my withdrawal statement. I understand if the authorization was obtained as a condition of obtaining insurance coverage, other law provides MercyCare with the right to contest a claim under the policy or the policy itself.
Marketing – I understand if MercyCare uses this authorization for marketing activities, I will be informed if they receive any direct or indirect payment in connection with the use or disclosure of my information.
Right to Inspect or Copy the Health Information to be used or disclosed – I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting MercyCare Customer Service Department.
HIV Test Results – I understand my HIV test results may be released without authorization to persons/organizations that have access under State law and a list of those persons/organizations is available upon request.

REDISCLOSURE NOTICE: I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

EXPIRATION DATE: This authorization is good until (indicate date or event) _____.
By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE OF MEMBER/LEGAL REP: _____ DATE: _____

(if signed by other than individual, state relationship) _____

MERCYCARE USE ONLY.

Date request received: _____

Extension requested: _____ Yes _____ No

If yes, give reason: _____

_____

Member notified in writing on this date: _____

Date PHI sent to requestor: _____

Staff member processing request: _____ Date: _____

Privacy officer verification: _____ Date: _____