UNION HEALTH - AN INTEGRATED HEALTH PLAN

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I ____________________________ who resides at ____________________________

in the city of ____________________________ in the state of ______________ hereby authorize:

Name: Integrated Health Plan ____________________________
(PHYSICIAN, HOSPITAL, CLINIC, LAB, REDIOLOGY CENTER OR OTHER HEALTHCARE PROVIDER)

Address: PO Box 427 ____________________________

City, St., ZIP: Columbus, Indiana, 47202 ____________________________

to disclose the following specific medical information by ☐ mail or ☐ fax or ☐ e-mail or ☐ phone to:

Name: ____________________________

Address: ____________________________

City, St., ZIP: ____________________________

Relationship to member: ____________________________

from the Health Records of:

Name: ____________________________
(NAME OF INDIVIDUAL WHOSE HEALTH RECORD IS BEING DISCLOSED)

Address: ____________________________

City, St., ZIP: ____________________________

For the purpose of: ____________________________

My authorization extends only to those data elements/documents initialed below:

______________ Statements of charges or payments (Explanation of Benefits (EOB), Provider Remittance Advice or similar documents)

______________ Records of visits (all visits)

______________ Record of visit for a specific date or dates Specific dates include or are limited to: ____________________

______________ Copies of records provided to the above name (i.e. hospital, lab, clinic, etc.)

______________ Progress Notes

______________ Photographs, Videotapes, Digital or other Images

______________ Discharge Summary

______________ History and Physical Examination

______________ Consultation Reports

______________ All of the above

______________ Other (Must be specific) ____________________________

______________ Mental Health and/or Alcohol and Drug Abuse Treatment

______________ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Information

______________ Hepatitis Information

This authorization is given freely with the understanding that:

Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

A photocopy or fax of this authorization is as valid as this original.

I may revoke this authorization at any time, except where information has already been released. The revocation must be in writing.

Integrated Health Plan, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

PATIENT'S NAME PRINTED

DATE

PATIENT'S SIGNATURE (OR GUARDIAN, IF A MINOR)

SOCIAL SECURITY NUMBER (FOR IDENTIFICATION PURPOSES ONLY)

MEMBER ID NUMBER

PATIENT'S PERSONAL REPRESENTATIVE

DATE

PATIENT'S PERSONAL REPRESENTATIVE'S AUTHORITY TO ACT

WITNESS

Email signed and completed to:
Member.Services@unionihp.org or mail to the address listed above.