Medica.
PO Box 9310
Minneapolis, MN 55440-9310

**Authorization to Disclose Protected Health Information (PHI)**
**to a Designated Individual or Representative**

**1. Member information**

Member Name: _____
Date of Birth (month/day/year): _____/_____/_____
Mailing Address: _____
_____
_____
Group #: _____ ID #: _____ Telephone Number: _____

**2. I authorize Medica to disclose my health information to the following person:**

Name: _____
Mailing Address: _____
_____
_____
Telephone Number: _____
Relationship: _____

**3. Information to be disclosed:**
(Contact your provider directly if you need to request medical records)

☐ I authorize disclosure of all medical, pharmacy, and insurance information.

☐ I authorize only the disclosure of the following information:
_____
_____
_____

The following information requires special consent by law. Even if you indicate that you authorize disclosure of all medical and pharmacy information, you must specifically request the following information in order for it to be released:

☐ Chemical dependency program.
☐ Psychotherapy notes.

**4. I understand that:**

- I may revoke this authorization at any time by writing to Medica at the address on your member ID card.
- If Medica has already disclosed health information based on my authorization, my request to revoke will not work for that PHI.
- When the PHI is disclosed to the third party named in Section 2, the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws. Note: substance abuse information may be protected by federal confidentiality laws.

- Medica will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization form.
- I may keep a copy of this authorization after signing it.
- This authorization will terminate in one of two ways, whichever is earlier:
  (1) It will end **one year** from the date the form is signed in Section 6, or
  (2) Here, I have stated the specific date or event that will terminate my authorization for this disclosure:
  **Date**: _____/_____/_____ or **Event:** _____
  _____
  _____

**5. Signature required of member or personal representative:**

- If the member is age 18 or older, they must sign this form.
- If signed by a personal representative, also submit a copy of legal authorization (for example: power of attorney, legal guardian, foster parent, parent).
- If the member is 12 or older and the information is related to behavioral/mental health, or substance use, member must sign.
- If the information is related to pregnancy, the member must sign regardless of age.

**Signature of member or personal representative:** _____

**Date**: _____/_____/_____

**Personal representative's relationship to member** (if applicable): _____

**Return completed form to:** Medica Health Plans
PO Box 267008
Weston, FL 33326

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## Discrimination is Against the Law

Medica complies with applicable Federal civil rights laws and will not discriminate against any person based on his or her race, color, creed, religion, national origin, sex, gender, gender identity, health status including mental and physical medical conditions, marital status, familial status, status with regard to public assistance, disability, sexual orientation, age, political beliefs, membership or activity in a local commission, or any other classification protected by law. Medica:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: TTY communication
- Written information in other formats (large print, audio, other formats)
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters and information written in other languages

If you need these services, contact the number on the back of your identification card. If you believe that Medica has failed to provide these services or discriminated in another way on the basis of your race, color, creed, religion, national origin, sex, gender, gender identity, health status including mental and physical medical conditions, marital status, familial status, status with regard to public assistance, disability, sexual orientation, age, political beliefs, membership or activity in a local commission, or any other classification protected by law, you can file a grievance with: Civil Rights Coordinator, Mail Route CP250, PO Box 9310, Minneapolis, MN 55443-9310, 952-992-3422, TTY: 711, civilrightscoordinator@medica.com.

You can file a grievance in person or by mail, fax, or email. You may also contact the Civil Rights Coordinator if you need assistance with filing a complaint. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201 800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

**If you want free help translating this information, call the number included in this document or on the back of your Medica ID card.**

Si desea asistencia gratuita para traducir esta información, llame al número que figura en este documento o en la parte posterior de su tarjeta de identificación de Medica.

Yog koj xav tau kev pab dawb kom txhais daim ntawv no, hu rau tus xov tooj nyob hauv daim ntawv no los yog nyob nraum qab ntawm koj daim npav Medica ID.

如果您需要免費翻譯此資訊，請致電本文檔中或者在您的Medica ID卡背面包含的號碼。

Nếu quý vị muốn trợ giúp dịch thông tin này miễn phí, hãy gọi vào số có trong tài liệu này hoặc ở mặt sau thẻ ID Medica của quý vị.

Odeeffannoo kana gargaarsa tolaan akka isinii hiikamu yoo barbaaddan, lakkoobsa barruu kana keessatti argamu ykn ka dugda kaardii Waraqaa Eenyummaa Medica irra jiruun bilbila'a.

إذا كنت تريد مساعدة مجانية في ترجمة هذه المعلومات، فاتصل على الرقم الوارد في هذه الوثيقة أو على ظهر بطاقة تعريف ميديكا الخاصة بك.

Если Вы хотите получить бесплатную помощь в переводе этой информации, позвоните по номеру телефона, указанному в данном документе и на обратной стороне Вашей индентификационной карты Medica.

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປຂໍ້ມູນນີ້ຟຣີ, ໃຫ້ໂທຫາເລກໝາຍທີ່ມີຢູ່ໃນເອກະສານນີ້ ຫຼື ຢູ່ດ້ານຫຼັງຂອງບັດ Medica ຂອງທ່ານ.

이 정보를 번역하는 데 무료로 도움을 받고 싶으시면, 이 문서에 포함된 전화번호나 Medica ID 카드 뒷면의 전화번호로 전화하십시오.

Si vous voulez une assistance gratuite pour traduire ces informations, appelez le numéro indiqué dans ce document ou au dos de votre carte d'identification Medica.

နမ့်အခ်ိဳးတ်ကျိုးထံစၢးကလီန့်နၤတ်ဂ့ၢ်တ်ကျိၤအံၤလၢအကလီန့်ဉ်, ကိးလီတဲစိနီဉ်ဂ်ၢ်လၢအပဉ်ယုဉ်လၢလံာ်တီလံာ်မီအပူၤအံၤမ့တမ့ၢ်ဖဲနန့နီဒခလေံာ်ဏုဉ်သးခးကွအလီၢ်ခံတကပၤအဖီခိဉ်နှဉ်တကွၢ်.

Kung nais mo ng libreng tulong sa pagsasalin ng impormasyong ito, tawagan ang numero na kasama sa dokumentong ito o sa likod ng iyong Kard ng Medica.

ይህን መረጃ ለመተርጎም ነጻ እርዳታ የሚፈልጉ ከሆነ በዝ ህ ሰነድ ዉስጥ ያለውን ቁጥር ወይም Medica መታወቅያ ካርድዎ በስተጀርባ ያለውን ይደውሉ።

Ako želite besplatnu pomoć za prijevod ovih informacija, nazovite broj naveden u ovom dokumentu ili na poleđini svoje ID kartice Medica.

Díí t'áá jíík'e shá ata' hodoonih nínízingo éí ninaaltsoos Medica bee néího'dílzinígí bine'déé' námboo bikí'ágííjį' béésh bee hodíilnih.

Wenn Sie bei der Übersetzung dieser Informationen kostenlose Hilfe in Anspruch nehmen möchten, rufen Sie bitte die in diesem Dokument oder auf der Rückseite Ihrer Medica-ID-Karte angegebene Nummer an.