PreferredOne®

MAIL OR FAX:
PreferredOne - Attn: Customer Service
6105 Golden Hills Drive - Golden Valley, MN 55416
FAX: (763) 847-
ATTENTION:

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Directions: Complete the name and address section immediately below, and each and all of sections 1 through 7, and execute and return the form to PreferredOne. NOTE: The authorization is not valid or effective until you (or a personal representative) properly complete each section, and execute and return the form to us. For questions about this form, please call PreferredOne Customer Service at (763) 847-4477

FULL NAME (FIRST, MIDDLE AND LAST):	PREVIOUS LAST NAME, IF ANY:

STREET ADDRESS	CITY	STATE:	ZIP CODE:

BIRTH DATE:	PHONE NUMBER:	MEMBER OR ENROLLEE ID NUMBER:	EMPLOYER OR GROUP NUMBER:

1. **Select all PreferredOne entity(ies) that you authorize to release and/or disclose your Health Information** *(Select the applicable PreferredOne entity(ies) through which you have been enrolled in coverage)*:
   a. ☐ PreferredOne Insurance Company
   b. ☐ PreferredOne Community Health Plan
   c. ☐ PreferredOne Administrative Services, Inc.

2. **Identify the Health Information that you authorize PreferredOne to disclose to others** *(Select one)*:
   Your "Health Information," includes, but is not limited to: (i) your "protected health information" or "PHI" as defined by the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA"); and (ii) your "health records" as defined by Minnesota Statutes section 144.293, as amended from time to time. Your Health Information includes your past, present and future Health Information, and includes but is not limited to, medical and pharmacy claims, and related case notes and information derived from them; and which specifically include, if PreferredOne has them, claims and case notes and information derived from them about HIV/AIDS, and mental health and substance use *(except see section 3 about psychotherapy notes and certain substance use information)*.
   a. ☐ All of my Health Information for all dates and periods of time.
   b. ☐ All of my Health Information for the following specific date or dates or period(s) of time: _____
   _____
   c. ☐ Include only the following Health Information: _____
   _____

3. **Psychotherapy notes, or substance use disorder information derived from a treatment program or health care provider that receives federal funding.** Federal law requires specific consent for the release of this information. **Even if you complete item 2, you must complete this section to authorize us to release any psychotherapy notes that PreferredOne possesses, or to authorize us to release certain substance use disorder information derived from a treatment program or health care provider that receives federal funding.** Any information received, disclosed or used pursuant to this section 3 is your Health Information.

Psychotherapy Notes
   a. ☐ Include all psychotherapy notes.
   b. ☐ Include only psychotherapy notes for the following date(s)/time period: _____
   _____
   c. ☐ Include only the following psychotherapy notes:
   _____
   _____

Substance Use Disorder Information
   a. ☐ Include all substance use disorder information for all dates and periods of time.
   b. ☐ Include all substance use disorder information for the following date(s)/time period:_____
   _____
   c. ☐ Include only the following psychotherapy notes:
   _____
   _____

4. **Identify the person(s) and/or entity(ies) to whom or to which you authorize PreferredOne to release and disclose your Health Information** *(Provide complete name, relationship (if a family member or friend), company name if applicable, address and phone number. Add an attachment if more space is needed.)***:**

a. Family member or friend: _____

_____

_____

b. Provider and/or clinic: _____

_____

_____

c. Lawyer and/or law firm: _____

_____

_____

d. Other person or entity: _____

_____

_____

5. **Identify the reason for the release or disclosure or your Health Information:**

a. ☐ Member's request
b. ☐ Payment
c. ☐ Appeal of a denied claim
d. ☐ Legal/litigation
e. ☐ Other (explain): _____

_____

_____

6. **Identify the date this authorization expires** *(Select one)***:**

a. ☐ This authorization is effective until my PreferredOne health coverage ends
b. ☐ This authorization is effective for one year from the date I sign it.
c. ☐ This authorization is effective for less than one year from the date I sign it, and until _____

7. **Acknowledgements and Signature**

By executing this Authorization, I understand and agree that:

- This authorization allows PreferredOne Administrative Services, Inc. and its affiliates, PreferredOne Community Health Plan and PreferredOne Insurance Company (collectively "PreferredOne"), to release and disclose my Health Information.
- I have not been required to sign this form and am doing so voluntarily. I am not required to sign this form to receive health benefits.
- I may inspect or copy the Health Information that is released or disclosed.
- I may prospectively revoke this authorization at any time by contacting PreferredOne. If I do revoke this authorization, it will only stop the release of Health Information in the future and does not apply to Health Information already released.
- Once it is released, the Health Information that is used or disclosed pursuant to this authorization is no longer protected by PreferredOne. The recipient might re-disclose it.

Signature of Member: _____ **Date:** _____

Print Member Name: _____

Signature of Personal Representative*: _____ **Date:** _____

Print Name and Relationship to Member: _____

*If you are a personal representative of the member as defined by HIPAA, you must submit the applicable documentation, below, that establishes your authority:

Power of Attorney – *Valid power of attorney document* ***Guardian** – Valid court order appointing you as guardian* ***Executor** – Valid court order appointing you as executor of a decedent's estate*

Date Received by PreferredOne _____ Initials _____ 8/2018