## HIPAA Authorization To Release Confidential Medical Information

**Recipient: Mid-America Associates, Inc.**

NAME OF MEMBER:____________________________________MEMBER ID:______________________________

PATIENT NAME:__________________________ DATE OF BIRTH:____________GROUP NUMBER____________

AUTHORIZATION

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider ("Provider") that has provided payment, treatment, consultation, advice or services to or on behalf of myself (or the person whom I represent) as listed above ("Member") to disclose the entire medical record, prescription history, medications prescribed and any other protected health information concerning the Member to Mid-America Associates, their employees, agents or representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) Infection and information on the diagnosis and treatment of mental illness and substance abuse (excluding psychotherapy notes).

I acknowledge by my signature below, that I agree and authorize any Provider to release and disclose the entire medical record without restriction.

The purpose of this disclosure is to evaluate my application for health coverage or claim for benefits made so that Mid-America Associates, Inc. may:

1) Administer coverage, review appeal or determine eligibility.
2) Underwrite an application for life insurance coverage or medical Plan coverage, make eligibility, Policy, Plan issuance or enrollment determinations.
3) Administer claims and determine responsibility for coverage and provisions of benefits.
4) Validate enrollment application statements.

This authorization shall be effective immediately and remain in force for a period of 12 months following the date of my signature below. A copy of this authorization is as valid as the original. By providing written notification to Mid-America Associates, I understand that I may revoke this authorization at any time. I understand that a revocation is not effective in the event a Provider has already relied on this Authorization to disclose information about the Member or to the extent that Mid-America Associates has a legal right to contest a claim under an insurance Policy, the self-funded health Plan or to contest the Policy or medical Plan itself. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information. Mid-America Associates will not re-disclose except as authorized by me or as required under law.

I understand that Providers may not refuse to provide treatment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, Mid-America Associates may not be able to process an application for coverage, or if coverage has been issued, may not be able to make any benefit determinations, appeal determinations or payments. I understand that any authorized representative or I will receive a copy of this authorization upon request.

SIGNATURE OF MEMBER OR AUTHORIZED REPRESENTATIVE

1.________________________________________ __________________________
Signature of Patient or Authorized Representative Date

**<u>Protected Health Disclosure Authorization</u>**

My signature below acknowledges and authorizes Mid-America Associates to disclose pertinent protected health information for purposes of conducting an External Review.

2.________________________________________ __________________________
Signature of Patient or Authorized Representative Date