

MID-AMERICA ASSOCIATES, INC.  
560 Kirts Blvd. Suite 125  
Troy, MI 48084

**Authorization for Release of Protected Health Information**

Issued: \_\_\_\_\_

Effective: \_\_\_\_\_

Revised: \_\_\_\_\_

Approved By: \_\_\_\_\_

Vice President, Compliance Officer

Expires: \_\_\_\_\_

**Policy:**

Mid-America Associates requires an authorization for the disclosure of Protected Health Information (PHI) beyond the restriction established by the HIPAA Privacy standard 45 CFR Parts 160 through 164. Mid-America Associates is the Third-Party Administrator for the self-funded Plan named below. Mid-America has a valid Business Associate Agreement with the Plan who is the Covered Entity.

**PLAN:** \_\_\_\_\_  
(Covered Entity)

**General Requirements:**

1. Mid-America Associates will disclose protected health information without an authorization to the individual receiving care, for those activities that are required to carry out treatment, payment, or health care operations except for psychotherapy notes, or those circumstances required by law. The disclosure of any PHI beyond this limitation will require an authorization.
2. An authorization by the individual receiving care or their personal representative will be required by Mid-America before disclosing protected health information beyond those limitations established by the Privacy standards.
3. An authorization must contain at least the following elements:
  - a. A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion.
  - b. The name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure.
  - c. An expiration date or an expiration event.
  - d. A statement of the individual's right to revoke the Authorization in writing.
  - e. A statement that the self-funded plan does not condition payment, eligibility or enrollment of health care services on the individual signing of the authorization.
  - f. A signature of the individual and date when Mid-America Associates obtained or received a valid authorization for its use or disclosure of protected health information.

SIGNATURE OF EMPLOYEE AUTHORIZING RELEASE OF PERSONAL HEALTH INFORMATION TO  
AUTHORIZED REPRESENTATIVE:

EMPLOYEE: \_\_\_\_\_

MEMBER ID NUMBER: \_\_\_\_\_

GROUP NUMBER: \_\_\_\_\_

GROUP (EMPLOYER) NAME: \_\_\_\_\_

THE AUTHORIZED REPRESENTATIVE IS APPOINTED FOR:

NAME (PATIENT) \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE OF PATIENT (CHILD IF AGE 18 YEARS OR OLDER)

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF EMPLOYEE (IF PATIENT IS A MINOR)

\_\_\_\_\_  
DATE

AUTHORIZED  
REPRESENTATIVE: \_\_\_\_\_

PRINT FULL NAME

\_\_\_\_\_  
DATE

SIGNATURE OF AUTHORIZED REPRESENTATIVE: \_\_\_\_\_

ADDRESS & TELEPHONE NUMBER OF ASSIGNED AUTHORIZED REPRESENTATIVE:

\_\_\_\_\_  
\_\_\_\_\_

RETURN TO ADMINISTRATOR:  
MID-AMERICA ASSOCIATES, INC.  
560 KIRTS BLVD. SUITE 125  
TROY, MI 48084  
FAX: (248) 583-4647

