

AUTHORIZATION TO RELEASE HEALTH-RELATED INFORMATION

For use by Members, or Personal Representatives of Members, of the PacifiCare Health Plan or the Secure Horizons Medicare + Choice Plan.

Name of Member whose Protected Health Information will be disclosed		
Last Name	First Name	Member ID#

I authorize PacifiCare to release protected health-related information to my designee		
Designee's Name Fred Dorrell	Designee's Relationship to Member/Covered Person UAW Benefits Representative	Designee's Phone # 918-254-5238
Designee's Address Tulsa Glass Plant, P.O. 555, Tulsa, OK 74102-0555		
Effective Date	Expiration Date (not to exceed 24 months)	

This authorization specifically allows PacifiCare to disclose protected information at the request of the Member or Personal Representative of the Member. **The reason for the authorization is (check one):**

- To act on my behalf
- To have access to my health information
- Other: _____

This authorization specifically allows PacifiCare to disclose protected information related to **(check all that apply):**

- Access to care (e.g. appointment availability)
- Continuity of Care (e.g. continuation of treatment for a serious medical condition with a terminated Provider)
- Unpaid claims
- Enrollment status/Premium billing information
- Balance billing
- Primary Care Physician change
- Demographic changes (e.g. address, telephone number, name*)

*Secure Horizons Members must request the changes with the Social Security office as well.

Please Attach any relevant documentation (e.g. doctor's bill)

PacifiCare understands you may have already sought assistance on the above issue by calling our Customer Service department and the issue has not been resolved satisfactorily.

I would like PacifiCare to respond **(check one):**

- Directly to my designee with the information requested.
- Directly to me with the information requested.
- To both my designee and me with the information requested.

Authorization

This release shall become effective as of my signature date shown below I also understand this authorization does not allow my designee to make any medical decisions on my behalf. I am aware that PacifiCare may not disclose any medical information or records related to special conditions including, but not limited to, mental health or rehabilitation, alcohol or drug abuse dependency, HIV testing, diagnosis, and treatment and genetic testing results. I am aware that the disclosed health information may no longer be protected by the privacy rule once it is disclosed to the designee.

I understand that I have a right to access the information used or disclosed, as part of this request. I am aware that such revocation is not effective to the extent that the person authorized to use and/or disclose this information has acted in reliance upon this authorization. I understand that PacifiCare will not condition treatment, payment, enrollment or

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Authorization (Continued)

eligibility for benefits on my providing or refusing to provide this authorization. I understand that if I refuse to sign this authorization that the designee may not contact PacifiCare on my behalf. I further understand that the information disclosed by PacifiCare will have no affect on my employment. I agree to release my personally identifiable information as set forth above and am free to decline to be involved or to withdraw at any time without penalty or loss of benefits to which I am otherwise entitled through PacifiCare.

To revoke or limit this authorization please provide a written notice to PO. Box 400046, San Antonio, TX 78229
ATTN: PacifiCare/Secure Horizons Correspondence Team. If you have any questions regarding this authorization, contact PacifiCare Customer Service at 1-800-825-9355 or Secure Horizons Customer Service at 1-800-950-9355 (Telephone Device for the Hearing-Impaired (TDHI) is available at 1-800-557-7595). Customer Service is available Monday through Friday from 7:00 a.m. to 9:00 p.m.

I further acknowledge, by signing below, that I understand this authorization. Please sign and keep a copy of this form for your records.

Signature of Member	Date
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If you are a lawful, personal representative acting on the Member's behalf, please sign below

Name of Personal Representative	Signature of Personal Representative	Date
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