Authorization for Release of Personal and Health Information

A: MEMBER WHOSE INFORMATION IS TO BE RELEASED

Name: _____ DOB: _____ Contract #: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ ☐ Landline/home ☐ Cell Alt. phone (optional): _____ ☐ Landline/home ☐ Cell

I request and authorize Total Health Care* to release my personal and health information. This may include claims and billing information. It may also include medical records that Total Health Care has received from medical practitioners, including records regarding general medical care, alcohol and drug abuse treatment, psychological or psychiatric treatment, social services counseling, human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) or AIDS-related complex (ARC), communicable diseases or infections, venereal diseases, tuberculosis, hepatitis and demographic information. (*"Total Health Care" includes Total Health Care and Total Health Care USA.)

B: TYPE OF INFORMATION TOTAL HEALTH CARE MAY RELEASE (check one box)

☐ All of my information (including personal, health, demographic, claims, billing and medical records) **OR**

☐ Only my claims and billing information **OR**

☐ Other, such as information regarding a specific date of service or issue (explain): _____

_____

C: WHO MAY RECEIVE YOUR INFORMATION?

Individual/entity name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ ☐ Landline/home ☐ Cell Alt. phone (optional): _____ ☐ Landline/home ☐ Cell

D: WHAT IS THE PURPOSE OF THIS AUTHORIZATION? (check one box)

☐ At my request

☐ Other (explain): _____

E: WHEN WILL THIS AUTHORIZATION EXPIRE? (check one box)

Note: If I fail to list an expiration date or event below, this authorization will expire one year from the date signed.

☐ No expiration ☐ Upon my coverage termination ☐ Upon my death ☐ Upon my written revocation

☐ On the following date: _____ (MM/DD/YYYY) ☐ On the following event: _____

I understand that I may refuse to sign this Authorization. I may revoke this Authorization at any time by notifying Total Health Care in writing at the address listed below. The revocation will not be effective for information that Total Health Care discloses between the time that this Authorization is signed and when the revocation is received. If Total Health Care requested this Authorization, I understand that I have the right to receive a copy of this Authorization after I sign it. I understand that Total Health Care will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization. I understand that the persons to whom information is disclosed under this Authorization may possibly redisclose the information to others without my knowledge or consent, and therefore, the privacy of my personal and health information may no longer be protected by law.

F: SIGNATURE REQUIRED

If signed by a person other than the member, please check the relationship and provide proof of authority to do so:

☐ Parent of a minor child ☐ Legal guardian ☐ Power of attorney ☐ Personal representative of deceased member

Signature: _____ Printed name: _____ Date: _____

G: FINALIZE AND SEND (form must be fully completed)

Submit form via one of the following:

- Scan and email to: CustomerService@thcmi.com
- Fax to: **313.871.6406**
- Mail to: Total Health Care
  Attn: Customer Service Department
  3011 W. Grand Blvd., Suite 1600
  Detroit, MI 48202

THC form ID: _____

June 2020

This form satisfies all required elements of a valid authorization under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).