

# Authorization to Disclose Protected Health Information



**Return completed form to:**

Prevea360 Customer Service  
 Mail Route CP555  
 PO Box 9310  
 Minneapolis, MN 55440-9310

Fax: 952-992-3198

<b>1</b>	<b>MEMBER INFORMATION (person who's information will be disclosed)</b>		
Member Name:		Date of Birth (mo/day/year):	
Street Address:			
City:		State:	Zip:
Group/Policy #:		9 Digit ID #:	
Telephone Number:			
<b>2</b>	<b>AUTHORIZATION</b>		
<b>I am authorizing Prevea360 to disclose my health information to the following person listed:</b>			
Name:		Relationship:	
Street Address:			
City:		State:	Zip:
Telephone Number:			
<b>3</b>	<b>INFORMATION TO BE DISCLOSED (call your clinic directly if you need to request medical records)</b>		
<input type="radio"/> I authorize disclosure of all medical and pharmacy information, including mental health or substance abuse information, in my file to the person in Section 2 unless otherwise stated in this section. <input type="radio"/> I authorize only the disclosure of the following information:			
<b>4</b>	<b>HEALTH INFORMATION</b>		
The health information is being disclosed at the request of the member or personal representative.			

**5 STATEMENT**

**I understand that:**

- I may revoke this authorization at any time by writing to Prevea360.
- If Prevea360 has already disclosed health information based on my authorization, my request to revoke will not work for that health information.
- When the health information is disclosed to the third party named in Section 2 above, the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws. Note: drug and alcohol abuse information may be protected by federal substance abuse confidentiality laws.
- Prevea360 will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization form.
- I may keep a copy of this authorization after signing it.
- **This authorization will end one year from the date the form is signed in Section 6.**
- If I would like this authorization to end sooner, I will indicate the specific date or event to end it here:  
\_\_\_\_/\_\_\_\_/\_\_\_\_ Event:

**6 SIGNATURE**

**Required of member or personal representative:**

- If the member is 18 or older, they must sign this form.
- If signed by a personal representative, also submit a copy of legal authorization (for example: power of attorney, legal guardian, foster parent).

**Signature of member or personal representative:**

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**Personal representative's relationship to member:**

Relationship: \_\_\_\_\_