Authorization for Release of Protected Health Information

You May Refuse to Sign this Authorization

Complete this form to authorize the release of your protected health information. Your authorization will remain in effect until revoked. This authorization is not required for medical treatment or payment of your claims. This authorization is not used to release information for psychotherapy notes or behavioral health notes.

When requesting release of information to attorneys or the Railroad Company you must provide specific beginning and ending date(s) and types of information to be released.

Return this form by mail or fax to the address at the bottom of this page or fax to 801-595-2069. A copy of a notarized Power of Attorney may be submitted to authorize this request.

I hereby authorize the use or disclosure of my individually identifiable protected health information as described below. I understand that this authorization is voluntary. I understand that the released information may no longer be protected by federal privacy regulations if not released to a health plan or health care provider. This form authorizes release of information by Union Pacific Railroad Employes Health Systems and/or its Depot Drug Pharmacies.

Member Name: ______________________ Phone: (___) ____ - ______

Street Address: ______________________ Date of Birth: ____ / ____ / ______

____

City: ______________________ Sate: ____ Zip: ________

Email address: ______________________

Specific description of information that may be released (including date(s)).

You may use the back of this form or include additional dated and initialed pages.

- ☐ Dues/payment information
- ☐ Prescription and/or co-payment information
- ☐ Explanation of benefits, payments or denials
- ☐ All of the above
- ☐ Medical records (UPREHS Clinics only)
- ☐ Copies of claims
- ☐ Other ______________________ (Describe specific information)

Start date: ____ / ____ / ______ End date: ____ / ____ / ______

Release my protected health information to the following person(s) and/or legal representative:

______________________ (Print full name) ______________________ (Title or relationship to member)

The member or legal representative must read and initial the following statements.

I understand that:

a. My health care and UPREHS payment for my health care will not be affected if I do not sign this form. Initials ____

b. I may copy this form before or after I sign it, or I may request a copy of this completed form. Initials ____

c. I understand that this authorization will expire when I revoke it. Initials ____

d. I may revoke this authorization at any time by notifying UPREHS in writing. If I choose to revoke this authorization, it will have no affect on actions UPREHS may have taken before they received my revocation. Initials ____

______________________ ______________________

Signature of member or member's legal representative Date

(Complete the form before signing)

Additional details (if needed):