MERCYONE℠

Health Plan

3100 Easton Square Place
Suite 300
Columbus OH 43219
Phone: 800-240-3851
Fax: 833-256-2871

Release of Information Form

Submit completed form via fax to 1-614-546-3148 OR return this completed form to: MercyOne Health Plan - Enrollment Department, 3100 Easton Square Place Suite 300 - Health Plan, Columbus, Ohio 43219

I hereby authorize the release of information regarding my MercyOne Health Plan coverage to the individual(s) or organization(s) named below. I acknowledge that this form is intended solely for the release of the information as set forth below and cannot be used to authorize any action by the authorized person or organization on my behalf. I understand that this authorization is voluntary and made to confirm my direction. I understand that if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws. I understand that my eligibility for health benefits, my enrollment in MercyOne Health Plan and payment for services will not be affected by whether or not I sign this authorization.

I authorize the individual(s) or organization(s) named below to act on my behalf regarding the following matters:

1. All my MercyOne Health Plan monthly premium account information.
2. All medical information on file for me at MercyOne Health Plan including specific claim information.
3. All information regarding the management of my care.
4. All my MercyOne Health Plan enrollment and eligibility information.

Member's Information

Print Member's Name

Signature of Member | **Date**

Member's ID Number

Turn page – More Information on Back

The Person of Organization to Whom the Information May be Released

In the event we can't contact you, we may call or write to the person(s) listed below in regards to any authorized matter in which they may act on your behalf.

Name of Person/Organization to Whom Information Can Be Released		Relationship
Street Address of Person/Organization	**City**	**State**
Zip	**Phone Number of Person/Organization**	

Name of Person/Organization to Whom Information Can Be Released		Relationship
Street Address of Person/Organization	**City**	**State**
Zip	**Phone Number of Person/Organization**	

Name of Person/Organization to Whom Information Can Be Released		Relationship
Street Address of Person/Organization	**City**	**State**
Zip	**Phone Number of Person/Organization**	

MercyOne Health Plan will continue to release information as indicated on this form until we receive written notice from you.

MercyOne Health Plan (HMO/PPO) is a Medicare Advantage organization with a Medicare contract. Enrollment in the plan depends on contract renewal. Benefits vary by county. MercyOne Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sexual orientation, sex (defined as sex at birth, legal sex and/or sex stereotyping), and gender (includes gender identity, gender expression and/or pregnancy).
ATENCIÓN: is habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-240-3851 (TTY: 711). 注 意：如果您使用繁體 中文, 您可以免費獲得語言援助服務。請致電 1-800-240-3851 (TTY: 711).