MESSA®
Good health. Good business. Great schools.

1475 Kendale Blvd., PO Box 2560
East Lansing, MI 48826-2560
800.292.4910

messa.org

Authorization to use and disclose protected health information

1. Person authorizing release

First name	*Last name*		*Enrollee ID*
Address	*City*	*State*	*ZIP*
Preferred Telephone Number	*Date of Birth*		

2. Protected health information to be shared

☐ All information, including personal, health, demographic, claims, billing and medical records. **I understand this may include sensitive information regarding substance abuse, including alcoholism, sexually transmitted or communicable diseases, AIDS or HIV treatment and mental health services (not including psychotherapy notes).** I authorize disclosure of this sensitive information.

☐ I do not authorize disclosure of all information. I understand that by limiting the information to be shared, none of my protected health information can be viewed on the online member portal. Authorization for disclosure is limited to the following information (please describe in the space below):

____

____

____

____

3. Person or organization that may receive information

Name of person or organization

Purpose: ☐ At my request
☐ Other (describe) ______________________________

Note: *If you choose to share protected health information with a person or organization not legally required to obey privacy laws, then that information could be shared with others and would no longer be protected.*

4. Expiration and Revocation

This authorization will expire:
☐ When my MESSA coverage ends
☐ One year from the date signed
☐ On this date: _____/_____/_____

Note: If you fail to complete this section, your authorization will expire one year from the date signed.

You may revoke the authorization at any time by sending a written request using a standard form available on MESSA.org or by calling the MESSA privacy officer at 800.292.4910. Revocation will not affect actions taken prior to MESSA's receiving the revocation request.

5. Authorization

I hereby authorize the use or disclosure of my protected health information as specified above. I understand this authorization is voluntary and that MESSA will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I also understand that once my protected health information is used or disclosed by MESSA, MESSA is not responsible for the designated recipients' use or disclosure of the protected health information.

Signature	*Date*

If a representative signs this authorization on behalf of an individual, please specify the relationship to the individual, including the authority to sign. Please provide proof of the relationship to the individual unless the individual is your minor child.

Representative's name:	*Relationship to the individual and authority to sign:*

Sign and return this form to:
Privacy Officer, MESSA, PO Box 2560, 1475 Kendale Blvd., East Lansing, MI 48826-2560 or fax to 800.693.5160.
If you have questions, please call the privacy officer at 800.292.4910.

Rev. 7/28/17 Pr. 7/17 - 1PDF