

# Authorization for Release of Protected Health Information

## You May Refuse to Sign this Authorization

UPREHS Medicare Plans  
PO Box 161020  
Salt Lake City, UT 84116-1020  
Customer Services: 1-800-547-0421  
Fax Number: 801-595-2032

You must complete this form for all authorizations for 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. Return this form by mail or fax to the above listed address or fax number. 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 Employees Health Systems and/or its Depot Drug Pharmacies or Clinics. You must give specific beginning and ending date(s) and types of information for any release to attorneys or the Railroad Company.

Member Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
UPREHS ID Card # \_\_\_\_\_ Date of Birth \_\_\_\_\_  
(MM/DD/YYYY)  
Street Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_

Specific description of information that may be released (including date(s)). If you need more space, you may use the back of this form or include additional dated and initialed pages.

- |   |  |
|---|--|
| <input type="checkbox"/> Dues/payment information                     | <input type="checkbox"/> Medical records (UPREHS Clinics only) |
| <input type="checkbox"/> Prescription and/or co-payment information   | <input type="checkbox"/> Copies of claims                      |
| <input type="checkbox"/> Explanation of benefits, payments or denials | <input type="checkbox"/> Other _____                           |
| <input type="checkbox"/> All of the above                             | (Describe specific information)                                |

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  
(Complete the form before signing.)

\_\_\_\_\_  
Date

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