



Care Coordination Release of Information Form

Member Name:		Today's Date:	
Member DOB:		Member ID:	
Care Coordinator Name:		Care Coordinator Phone:	

UCare and Care Coordinator may release my information to:		
Name	Relationship	Address/Phone/Fax

Information I consent to release includes (check all that apply):							
<input type="checkbox"/>	Name/Address/Phone	<input type="checkbox"/>	Provider Records	<input type="checkbox"/>	Enrollment	<input type="checkbox"/>	Restricted Recipient Info
<input type="checkbox"/>	Claims/Authorizations or Utilization Review	<input type="checkbox"/>	Pharmacy and Medications	<input type="checkbox"/>	Genetic Testing	<input type="checkbox"/>	Financial
<input type="checkbox"/>	Appeals/Grievances	<input type="checkbox"/>	Disease Mgt Programs	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	Photo of me
<input type="checkbox"/>	Medical Records	<input type="checkbox"/>	Alcohol and Substance Use	<input type="checkbox"/>	Mental Health Care	<input type="checkbox"/>	Diagnosis
My records may be released from any time during my enrollment with UCare (up to 6 years prior) OR							
Records can be released for only some date(s) or time period:							

The reason for this release is:							
<input type="checkbox"/>	Member request	<input type="checkbox"/>	Continuity of Care	<input type="checkbox"/>	Disease Management	<input type="checkbox"/>	Research
<input type="checkbox"/>	Appeal/Complaint	<input type="checkbox"/>	To explain UCare's programs or services	<input type="checkbox"/>	Media Release	<input type="checkbox"/> Other (specify):	
This release will last until (specify date/event/condition):							



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Signature(s):

By signing this form:

- I agree that UCare may use and release information about me for the reasons checked above.
- I have the right to cancel this release in writing at any time by emailing:
or sending a written request to my care coordinator at:

- I understand and agree that even if I cancel this release, information might have already been shared before I canceled the release.
- Any information used or disclosed may no longer be protected by law. It may also be subject to re-disclosure by the person or organization receiving it.
- I understand that I do not have to sign this release.
- If I do not sign this release, it will not affect my health coverage.
- I understand that the information released may let others know that I am a person on a Minnesota health care program.
- I understand and agree to the terms in this release form.
- I hereby release UCare from any and all claims arising out of or in connection with the use of the released information.

Signature of Individual Authorizing Release	Date
Signature of Parent (if minor)/Legal Guardian	Date
Signature of Witness (if required)	Date