Release of information Form

Trinity Health Plan of Michigan

Return this completed form to:
Trinity Health Plan Of Michigan-Enrollment Department
3100 Easton Square Place Suite 300 – Health Plan
Columbus, Ohio 43219

You may also FAX this form to **614-546-3148**

I hereby authorize the release of information regarding my Trinity Health Plan Of Michigan 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 Trinity Health Plan Of Michigan 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 Trinity Health Plan Of Michigan monthly premium account information.
2. All medical information on file for me at Trinity Health Plan Of Michigan including specific claim information.
3. All information regarding the management of my care.
4. All my Trinity Health Plan Of Michigan enrollment and eligibility information.

Member's Information

Print Member's Name _____

Signature of Member _____ Date _____

Member's ID Number _____

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.

_____ _____
Print Name of person/organization to whom information can be released Relationship

_____
Street Address of person/organization City State Zip

_____
Phone Number of person/organization

_____ _____
Print Name of person/organization to whom information can be released Relationship

_____
Street Address of person/organization City State Zip

_____
Phone Number of person/organization

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