OmniCare Health Plan ("OCHP")
Authorization for Disclosure of Personal and Health Information

Name: _____ Address: _____

Social Security No.: _____ City/State/Zip: _____

Medicaid No.:_____ Date of Birth: _____

I request and authorize OCHP to disclose my personal and health information held by OCHP including claims and billing information, medical records created by medical practitioners that OCHP received, including records regarding general medical care, alcohol and drug abuse treatment, psychological or psychiatric treatment, social services counseling, human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) or AIDS related complex (ARC), communicable diseases or infections, venereal diseases, tuberculosis and hepatitis, and demographic information.

1. OCHP shall disclose all personal and health information it holds unless you request only the checked boxes:
   - ☐ Claims and billing information
   - ☐ Enrollment/Eligibility Information
   - ☐ Medical Management Information
   - ☐ Customer Service Records

2. Disclosure is to be made to (name, address, zip code, phone #): RECORDS DEPOSITION SERVICE, P.O. BOX 5054,SOUTHFIELD, MI 48086-5054 P: 248-357-3330 F: 248-357-3337

3. This disclosure is made at your request unless you note another reason: PRE-TRIAL DISCOVERY.

4. This authorization expires in one year unless you write in an earlier date: _____.

I understand that OCHP will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I understand that I may refuse to sign this authorization and that I may revoke it at any time but I must do so in writing to OCHP at 1155 Brewery Park Blvd., Suite 250, Detroit, MI 48207. The revocation will not be effective to the extent that OCHP has already disclosed the information. I understand that I have the right to receive a copy of this authorization after it is signed if OCHP requested it. I understand that the persons to whom information is disclosed under this Authorization may possibly re-disclose the information to others without my knowledge or consent and therefore the privacy of my personal and health information may no longer be protected by law. A faxed signature to OCHP shall be valid as an original.

_____ _____
Signature Date

If signed by a person other than the member, please state relationship and provide the proof of authority to sign.

_____ Legal Guardian
_____ Power of Attorney
_____ Advance Directive

_____ Personal Representative of living or deceased person
_____ Parent of minor child