Here’s UCare’s Release of Information Form

UCare’s Release of Information Form allows your personal information or medical records to be shared with a person or entity you name. This form also explains what information can be released, who can receive it and for what purpose.

Please fill out this Release of Information Form. Be sure to check the boxes that apply and sign it. Then, return the form to us by mail, fax or email. We list our mailing address, fax number and email address at the end of the form.

Where to reach us when you need help

We’re helpers, and we’re here for you when you need us. Feel free to call us at the number on the back of your member ID card if you have questions. You can also send us a request using your online member account at **member.ucare.org**.

Discrimination is against the law. UCare does not discriminate because of race, color, national origin, creed, religion, sexual orientation, public assistance status, marital status, age, disability or sex.

No English? **1-800-203-7225**
1-800-688-2534 (TTY)

Auxiliary Aids and Services. UCare provides auxiliary aids and services, like qualified interpreters or information in accessible formats, free of charge and in a timely manner, to ensure an equal opportunity to participate in our health care programs. **Contact** UCare at 612-676-3200 (voice) or 1-800-203-7225 (voice), 612-676-6810 (TTY), or 1-800-688-2534 (TTY).

ADA Advisory **1-800-203-7225**
1-800-688-2534 (TTY)

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U15061 (04/2025)

Release of Information Form

Member information

Member name: _____

Member date of birth: _____ UCare member ID#: _____

UCare may release my information to: _____
(person or entity to get my information)

Information to be released

The named person or entity above can access the following records and information. This person or entity may also change these records with UCare.

☐ I let UCare share all my records and information with my representative.

OR

☐ I let UCare share the following records with my representative:

☐ My name, address, phone number and UCare member ID# ☐ Claims information ☐ Pharmacy history ☐ Enrollment status and history ☐ Health management plans ☐ Utilization reviews	☐ Sexual health information or HIV/AIDS status ☐ Pregnancy status and fertility information ☐ Health care assessments ☐ Appeals and grievances ☐ Financial information	☐ Authorizations ☐ Psychological health care records ☐ Restriction information ☐ Other (please tell us): _____ _____ _____

Timeframe

☐ Release my records from any time during my enrollment.

OR

☐ Release my records from this specific timeframe only:

_____

Purpose for release

☐ As a personal request ☐ To explain UCare's programs or services ☐ Research ☐ Media release	☐ To send an appeal or grievance (complaint) ☐ Continuity of care and disease management ☐ Other (please tell us): _____

This release will last until _____,
or one year from the date of signature. (give a specific date, event or condition)

By signing this form, I understand and acknowledge that:

- UCare may use and release information about me for the above reasons.
- I have the right to cancel this release at any time by emailing **privacy@ucare.org** or writing to UCare's Privacy Officer at 500 Stinson Blvd. NE, Minneapolis, MN 55413.
- If I cancel this release, I understand that my information might have already been shared or relied upon before I canceled the release.
- When information is shared with the party named on this form, it may no longer be protected by federal or state privacy laws.
- If I don't sign this release, it won't affect my health coverage.
- The information released may let others know I'm in a Minnesota Health Care Program.
- I hereby release UCare from all claims resulting from or in connection with using the released information.

_____ _____
Signature of UCare member approving the release Date

_____ _____
Signature of witness (if needed) Date

_____ _____
Signature of parent, guardian or authorized representative (if needed) Date

Return this form to UCare in one of three ways:

Mail: UCare
PO Box 52
Minneapolis, MN 55440-0052

Fax: 612-676-6501

Email: **CLSScanReqInq@ucare.org**