



Release of Information

I authorize Mercy Health Plans, or its designated representative, to release information regarding my membership to the person(s) names below. I understand that this authorization will remain in effect until I notify Mercy Health Plans in writing that I revoke this authorization.

Please *print* the name of each person and their phone number that you authorize to receive information:

Name:	Phone:
_____	_____
Name:	Phone:
_____	_____
Name:	Phone:
_____	_____
Name:	Phone:
_____	_____

Check one:

- I give authorization for the above named person(s) to receive information only.
- I give authorization for the above named person(s) to receive information, and to change my Primary Care Physician on my behalf.

Member's Signature or Power of Attorney: _____

Member's Identification Number: _____

Date: _____