AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

A. INFORMATION – This is the individual whose information will be released.
(Individuals over 18 years of age must complete their own form, except for legal Personal Representative situations.)

Person's Name: _____

Address (Street, City, State, and Zip Code): _____

Telephone Number: _____ E-Mail Address: _____

B. AUTHORIZED PARTY – This is the person or organization who will receive the Member's information.

I authorize _____ to release the above Member's Protected Health Information to:

_____ _____

_____ _____

C. INFORMATION TO BE RELEASED – If limiting disclosures, please describe. ***Check one box only*.**

☐ ALL information relating to provision or payment of healthcare benefits or services may be released.

☐ Other (please describe): _____

D. EXPIRATION AND REVOCATION - When this Authorization will end. ***Check one box only*.**

Expiration: *(check one box only)*

☐ Six (6) months (This option will apply if no other expiration is specified.)

☐ On this specific date _____ or occurrence of this event: _____

Revocation: You may revoke this Authorization at any time by notification in writing.

E. PATIENT SIGNATURE – Please sign and date below.

This Authorization is voluntary and completed at my own request. I understand that if the person or organization I have authorized to receive the information is not subject to federal health information privacy laws, the information may be re-disclosed and no longer be protected by federal privacy laws. I understand that giving this Authorization is not a condition of enrollment in a health plan or eligibility for benefits. This Authorization is not valid unless completely filled out, signed and dated by the Patient or by the Member's legal Personal Representative.

_____ _____

Signature of Patient (or Patient's Personal Representative) ** Date

** If the Patient is a dependent minor child, the child's parent or legal guardian must sign this form. This form may ***not*** be signed on behalf of the

F. PERSONAL REPRESENTATIVE INFORMATION – If you are signing this Authorization as the Person's Personal Representative, please complete this section and attach a copy of the legal document establishing this authority (except for parent of minor, dependent child).

Name of Personal Representative: _____

Relationship to the Patient:

☐ Parent of dependent minor child (copy of legal document is not necessary)

☐ Legal guardian or conservator *** ☐ Health Care Power of Attorney ***

☐ Executor or Administrator of Estate *** ☐ Other: _____ ***

*** Other than the parent of a dependent minor child, all other Personal Representatives must attach proof of their legal authority to this Authorization