AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

| A. INFORMATION – This is the individu (Individuals over 18 years of age must | ual whose information will be released. 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 | D – If limiting disclosures, please describe. <u>Check one box only</u> . |
| ALL information relating to provision or pay | yment 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 a | |
| | |
| E. PATIENT SIGNATURE – Please sig | n and date below |
| | y own request. I understand that if the person or organization I have authorized to |
| receive the information is not subject to federal heal protected by federal privacy laws. I understand that | Ith information privacy laws, the information may be re-disclosed and no longer be giving this Authorization is not a condition of enrollment in a health plan or eligibility for pletely filled out, signed and dated by the Patient or by the Member's legal Personal |
| Signature of Patient (or Patient's Personal I | Representative) ** Date |
| , | |
| ir the Patient is a dependent minor child, the child's p | parent or legal guardian must sign this form. This form may not be signed on behalf of the |
| | |
| | NFORMATION – If you are signing this Authorization as the Person's nplete this section and attach a copy of the legal document establishing ninor, dependent child). |
| Name of Personal Representative: | |
| Relationship to the Patient: | |
| Parent of dependent minor child (copy of le | egal document is not necessary) |
| Legal guardian or conservator *** | Health Care Power of Attorney *** |
| Executor or Administrator of Estate *** | Other:*** |
| — | other Personal Representatives must attach proof of their legal authority to this Authorization |