

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