Authorization For Release Of Protected Health Information

I hereby authorize NAME OF BENEFIT PLAN to disclose confidential information about the Plan Participant identified below.

I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY.

Please Print All Responses If you do not fill out both sides of this form completely, we may be unable to process your request. Incomplete authorization requests will be returned to you.

1. Member/Insured Information

Last Name		First Name	Middle Initial
Member ID Number	Social Security Number	Birth Date (MM/DD/YYYY)	Daytime Phone Number
Street Address		City, State, Zip Code	

2. I authorize the individual(s) or company(ies) identified below to receive confidential information pertaining to the member/insured named above.

Individual or company authorized to receive confidential information	Daytime Telephone Number
Street Address	City, State, Zip Code

Individual or company authorized to receive confidential information	Daytime Telephone Number
Street Address	City, State, Zip Code

Individual or company authorized to receive confidential information	Daytime Telephone Number
Street Address	City, State, Zip Code

3. Purpose(s) for this Authorization

This authorization is for my benefit plan:

- ☐ To respond to all requests for confidential information made by the individual(s) or company(ies) named in Section 2 above.
- ☐ To respond to requests for only the following specific information: (for example, disclosures about claims submitted by a certain provider)

If this authorization is limited to a specific time period, please indicate: from (m/d/y) _____through (m/d/y) _____

4. Type of coverage to which this authorization applies (check all that apply)

☐ Disability ☐ Long Term Care ☐ Health (includes medical, dental, pharmacy, vision, and flexible spending account)

5. Description of the information to be released or disclosed: (check all that are appropriate)

☐ Enrollment information ☐ Claim records ☐ Claim status ☐ Patient medical records

☐ Other: (please specify) _____

6. IMPORTANT: Your signature below means that you understand and agree to the following:

- The protected health information provided under this authorization may include diagnosis and treatment information, including information pertaining to chronic diseases, behavioral health conditions, alcohol or substance abuse, communicable diseases, including HIV/AIDS, and/or genetic marker information. These records will be included in the information we will make available to the individual(s) or company(ies) identified in Section 2 above.

- This authorization is intended to following the disclosure requirements of the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Standards") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"). An authorization is required by the Privacy Rule for uses and disclosures of PHI not otherwise allowed by the Rule. Where the Privacy Rule requires patient authorization, voluntary consent is not sufficient to permit a use or disclosure of protected health information unless it also satisfies the requirements of a valid authorization. An authorization is a detailed document that gives covered entities permission to use protected health information for specified purposes, which are generally other than Treatment. Payment, or health care Operations (TPO), or to disclose protected health information to a third party specified by the individual. Information disclosed under this authorization may be re-disclosed by the recipient and no longer protected by federal privacy regulations.

- If we receive requests for copies of claims and encounter information from the individual or company you have authorized to receive your confidential information, we may charge a reasonable fee (except where prohibited by law) to defray our copying and mailing costs.

- Your ability to enroll in the Plan, your eligibility for benefits and payment for services will not be affected if you do not sign this form. (However, without your signature, your request to release the information described above to a third party will not be honored.)

- You may receive a copy of this form if you ask for it by writing to the address listed at the bottom of this page.

- This authorization will expire one year from the date you sign this authorization, unless you indicated a shorter time-frame on the front of this form. If you sign this form, you may revoke the authorization at any time by notifying the Plan in writing at the address below. Revoking this authorization will not have any effect on actions that the Plan took in reliance on the authorization before we received the notification.

7. Signature of Member/Insured or Member/Insured's Legal Representative or Member/Insured's Parent (if Member/Insured is an un-emancipated minor child)

Signature	Date

Print Name

If the person signing this Authorization is not the Member, describe relationship to the Member:

- ☐ Natural or Adoptive Parent of Un-emancipated Minor Child
- ☐ Legal Representative (i.e., someone with legal authority to act on the Member/Insured's behalf)

If this authorization is being signed by Member/Insured's legal representative (other than a parent of an un-emancipated minor child), you must furnish a copy of the health care power of attorney, or other relevant document authorizing you to act on the Member/Insured's behalf.

Send this form and direct any questions you may have to the following:

Privacy Officer
Name Of Plan
Address
City, State, Zip Code