Authorization for Release of Protected Health Information (PHI)

I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY.

This form is used to release your protected health information as required by federal and state privacy laws. Your authorization allows the party name on this form to release/receive your protected health information to a person or organization that you choose. You can revoke this authorization at any time by providing such request in writing. Revoking this authorization will not affect any action taken prior to receipt of your written request.

SECTION I. Please Print

Participant Information: Last Name	First	SS#

Insured/Patient's Name
Contact Telephone Number (include Area Code)

SECTION II.

I AUTHORIZE THE FOLLOWING INDIVIDUAL(s) AND/OR COMPANY(ies) IDENTIFIED BELOW TO RELEASE/RECEIVE CONFIDENTIAL HEALTH INFORMATION PERTAINING TO THE PARTICIPANT/PATIENT LISTED ABOVE.

Individual/Company authorized to receive confidential information	Daytime Telephone (include Area Code)
1.	
2.	
3.	

SECTION III.

PURPOSE(s) for this AUTHORIZATION

[] To respond to all requests for confidential information made by the individual(s) /company(ies) named above.

[] To respond to requests for only the following specific information; (IE: claims submitted by a specific provider)

_____

_____

_____

[] To respond to requests for information for a specific period of time: please indicate: from_____through_____

TYPE OF COVERAGE TO WHICH THIS AUTHORIZATION APPLIES (check ALL that applies)

[] Medical [] Prescription [] Dental [] Vision

DESCRIPTION OF INFORMATION TO BE RELEASED OR DISCLOSED: (check ALL that applies)

[] Application/Enrollment/Eligibility [] Claim Records [] Claim Status [] Patient/Case Management Records

[] Other: Please Specify _____

IMPORTANT: YOUR SIGNATURE BELOW MEANS THAT YOU UNDERSTAND AND AGREE TO THE FOLLOWING:

1. **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 may be available to the individual(s)/company(ies) identified in Section II above.**
2. **Information disclosed under this authorization to an individual(s)/company(ies) not subject to federal health information privacy laws may be redisclosed by the recipient and no longer protected by federal privacy regulations.**
3. **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.)**
4. **If you sign this form, you may revoke the authorization at any time by providing a written request. Revoking this authorization will not have any effect on actions taken in reliance on the authorization received prior to the revocation.**

I hereby authorize my medical providers to disclose/receive confidential information about the patient identified above.

Signature of Participant, Insured, Insured's Legal Representative, or Insured's Parent/Legal Guardian (if insured is an non-emancipated minor child)

_____

Print Name Date

If the person signing this Authorization is not the Participant/Insured, describe relationship to the Insured:

[] Natural or Adoptive Parent of non-emancipated Minor Child

[] Legal Representative (i.e.: someone with legal authority to act on insured's behalf)

If this authorization is being signed by Participant/Insured's legal representative (other than a parent of a non-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 Participant/Insured's behalf.