



**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

INFORMATION ABOUT THE USE OR DISCLOSURE

Authorizing individual's name: \_\_\_\_\_

Authorizing individual's social security number: \_\_\_\_\_

Employee's name: \_\_\_\_\_

Employee's social security number: \_\_\_\_\_

This authorization relates to the health plan(s) of \_\_\_\_\_ (hereinafter referred to as the "Plan"). I authorize the use or disclosure of my individually identifiable health information by or to any family member, any health care provider, the Plan Sponsor, the insurer/TPA of the Plan, or any other entity providing services in connection with the Plan in order to process my enrollment in the Plan or to process any claim for my Plan benefits. This authorization is effective until the date I terminate enrollment in the Plan.

IMPORTANT INFORMATION ABOUT YOUR RIGHTS

I have read and I understand the following statements about my rights:

- I may revoke this authorization at any time before its expiration date by notifying the Plan in writing, but the revocation will not have any effect on any actions the Plan took before it received the revocation.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).
- The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity.

SIGNATURE OF INDIVIDUAL OR INDIVIDUAL'S REPRESENTATIVE

\_\_\_\_\_  
Signature of Individual or Individual's Representative

\_\_\_\_\_  
Date

NOTE: This form MUST be completed before signing.

Printed name of the individual's personal representative: \_\_\_\_\_

Relationship to the individual, including authority for status as representative:  
\_\_\_\_\_