



AUTHORIZATION FOR DISCLOSURE OF AN INDIVIDUAL'S HEALTH INFORMATION

Employer Name: _____

Subscriber Or Dependent Whose Information Is To Be Disclosed

Please print information in this section.

_____	_____
Name	Plan Name
_____	_____
Street Address	Daytime Telephone
_____	_____
City	State ZIP Code

Person(s) Or Entity(ies) To Whom Information May Be Disclosed

Please print information in this section.

_____	_____
Name	Daytime Telephone
_____	_____
Street Address	Daytime Telephone
_____	_____
City	State ZIP Code

Information To Be Disclosed By The Employer At The Request Of The Authorized Individual

Check all that apply.

- Health Plan Benefit Information:** Includes information contained in your Plan Document and Summary Plan Description (e.g., plan design, eligibility and other benefit information.)
- Claims Information:** Includes information related to payment of your claims for services you received, including pertinent information located on a claim form (e.g., billed amount, general procedure descriptions, claim payment or denial reasons).
- Authorization Information:** Includes specific medical information related to claim requests and determinations.
- Premium & Contribution Information:** Includes information related to billing cycles, bank draft changes, etc.
- Services From Provider Or Supplier And Date(s):** _____ from _____ to _____
Includes information related to services rendered by a specific provider or supplier, during the specific time period.
- Other:** _____
Specify other information authorized for disclosure if it is not listed in one of the categories above. Please be specific regarding the reason for disclosure.
- Reason For Disclosure** (other than at the request of the authorized individual): _____

Length Of Time For Which This Authorization Is Valid

Under applicable law, this authorization is valid up to 24 months (or a shorter period of time if so indicated) or for a particular event that has occurred, as stated in the authorization. If you are making this authorization for an extended period, the authorization will have to be renewed after its expiration. This authorization will remain in effect until:

- 24 months from the date of signature of this authorization; **or**
- _____, but no longer than 24 months from the date of signature; **or**
(Month/Day/Year)
- All information relating to a certain event or injury has been provided (e.g., back injury from April 2002 or formal research).
Specify event(s) and approximate date(s) of event(s): _____

- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment, or my eligibility for benefits with my Employer. However, there may be consequences with the intended recipient of this information.
- I understand this authorization is not valid without the required signature.
- I understand I have the right to revoke this authorization at any time in writing, except to the extent that my Employer has already provided the information. To revoke this authorization, contact your human resource manager or payroll administrator.
- I understand that the recipient of this information may possibly re-disclose the information to others without my knowledge or authorization; therefore, the privacy law may no longer protect my information.

_____	_____	_____
Print Full Name	Signature	Date

Relationship/Authority

Please check one. Include legal documentation with this form for items marked with an asterisk (*) below.

- Member
- Parent of Minor Child
- Power of Attorney*
- Legal Guardian*
- Other Personal Representative Designation*

Tracking No. _____
Name _____