AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I. **INDIVIDUAL DATA**

Individual's Name: _____

Group Health Plan Name: _____

Group Number: _____

Address, City, State and Zip: _____

Telephone No.: _____

I authorize the use and disclosure of my protected health information as described below:

1. My protected health information is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, health plan, my employer, or a health care clearinghouse and that relates to: (1) my past, present or future physical or mental health or condition; (2) the provision of health care to me; or (3) the past, present or future payment for the provision of health care to me.

   _____

   _____

2. The following individual, organization or class of persons is authorized to use or disclose my protected health information:

   _____

   _____

3. The following individual, organization or class of persons is authorized to receive my protected health information:

   _____

   _____

4. The protected health information that may be used and disclosed is as follows:

   _____

   _____

   [Describe in as much detail as possible the protected health information that you wish to be used or disclosed. For example, the information to be used or disclosed may relate to payment, enrollment or claims. If so, you should include, if available, the types of claims, dates of service or types of service.]

5. My protected health information will be used or disclosed for the following purpose(s):

   _____

   _____

   [Describe the reason for each use and disclosure of the protected health information. If an individual initiates the authorization for his or her own purposes, insert "at the request of the individual."]

INDIVIDUAL

Individual's Name: _____

6. I understand that if my protected health information is to be received by an individual or organization that is not a health care provider, health care clearinghouse or health plan covered by federal privacy regulations, my protected health information described above may be re-disclosed and no longer protected by federal privacy regulations.

7. I understand that if I refuse to sign this authorization that my Group Health Plan ("GHP") may refuse to enroll me or determine that I am not eligible for benefits. *[Use this statement only if the authorization is sought for health plan's underwriting or risk rating determinations prior to enrollment in the plan, and the authorization is not for a use or disclosure of psychotherapy notes.]*

8. I understand that I may refuse to sign this authorization. I further understand that my GHP will not condition enrollment in my GHP or eligibility for benefits on my signing this authorization. *[Use this statement only if the authorization is* not *sought for health plan's underwriting or risk rating determinations.]*

9. I understand that I may revoke this authorization at any time by sending a written notification to _____at _____, _____ and this revocation will be effective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective: (1) for information that my GHP already has used or disclosed, relying on this authorization or (2) if the authorization was obtained as a condition for coverage in my GHP and, by law, my GHP, has a right to contest the coverage.

10. The date/event this authorization expires: _____.

Individual Signature or Personal Representative: _____

Description of Personal Representative's Authority: _____

Date: _____ **Individual Name (Please Print):** _____

If the GHP is requesting authorization, the GHP must provide the individual with a signed copy of the authorization.