Authorization to Disclose Protected Health Information

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| **Primary account holder information** | | | |
| Last name | First name | | M.I. |
| Street address | City | State | ZIP |
| Email address (required) | Daytime phone  ( ) | SSN or ID number | |

This authorization will remain in effect for the duration of the state expiration requirement (may vary from 24-48 months) based off of primary

account holder’s state of residency. In addition, I may revoke this authorization at any time by notifying the recipient.

If at any time you need to alter this authorization form, please contact the recipient.

Purpose of authorization: At my request Family member assisting with health care Other:

Any limitations that I impose on the recipient with respect to this authorization are declared below:

My protected health information is individually identifiable health information, including demographic information collected from me or created

or received by a health care provider, a health plan, my employer, or a health care clearinghouse, and relates to: (i) my past, present, or future physical or mental health condition; (ii) the provision of the health care to me; or (iii) the past, present or future payment for the provision of health care to me.

In accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA), I, the undersigned, grant permission to the recipient to disclose protected health information (as defined in HIPAA) to the following person or persons:

**HIPAA authorization (to be completed by dependent)**

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| **Authorization of HIPAA disclosure (to be completed by dependent)** | |
| I understand that by granting this authorization, the person who obtains this information may disclose it to other individuals with or without my consent and in so doing, the information would no longer be protected under HIPAA. I understand that my authorizing the use and disclosure of my information is not a condition of enrollment in this health plan, eligibility for benefits or payment of claims. | |
| Dependent’s name (please print) | Date |
| Dependent’s signature | Dependent’s date of birth (mm/dd/yyyy) |
| **Note**: If the person signing above is a personal representative of the named individual, attach copy of document granting authority to the personal representative. | |

