AUTHORIZATION
FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize the use and disclosure of my protected health information as described 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 that relates to; (i) my past, present, future physical or mental health or condition; (ii) the provision of health care to me; or (iii) the past present, or future payment for the provision of health care to me.

The following individual (s), organization, or class of persons (e.g., group of individuals within the organization) is authorized to use or disclose my protected health information:

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The following individual(s), organization or class of persons is authorized to receive my protected health information:

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

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(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.)

I understand that if my protected health information is to be received by individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by federal privacy regulation, my protected health information described above may be re-disclosed and no longer protected by federal privacy regulation.

I understand that the Group Health plan or ________________________ will receive compensation for its use and/or disclosure of the information. ***(Use this statement only if the authorization is for marketing purposes and the health plan will receive reimbursement from a third party for the use and/or disclosure)***

I understand that if I refuse to sign this authorization that Group Health Plan my refuse to enroll me or determine that I am not eligible for benefits in the Group Health Plan. ***(Use this statement only if the authorization is sought for the health plan's underwriting or risk rating determinations. The authorization cannot be obtained for the purposes of using or disclosing psychotherapy notes.)***

I understand that I may refuse to sign this authorization. I further understand that the Group Health Plan will not condition enrollment in the Group Health Plan will not condition enrollment in the Group Health Plan 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 determination.)***

I understand that I may revoke this authorization at any time by sending a written notification to the privacy officer at ___________________________________, and this evocation will be effective for future uses and disclosure of protected health information. However, I further understand that this revocation will not be effective: (i) for information that has already been used or disclosed, relying on this authorization or (ii) if the authorization was obtained as a condition for coverage in the group health plan and, by law, the Group Health plan has a right to contest the coverage.

This authorization expires (identify a specific date or event)

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____ ________________

Signature of Individual or Personal Representative Date

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Name of Individual or Personal Representative

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Description of Personal Representative's Authority