HIPPA (Release of Information)
AUTHORIZATION FROM

I ______________________________ hereby authorize ____________________________ and its affiliates, its employees and agents (COLLETIVELY____________________________), to release to ______________________ (INSERT FULL NAME OF PERSON/ORGANIZATION) my personal health information maintained by ______________________________ (E.G., INFORMATION RELATING TO THE DIAGNOSIS, TERATMENT, CLAIMS PAYMENT, AMD HEALTH CARE SERVICES PROVIDED OR TO BE PROVIDED TO ME AND WHICH IDENTIFIES MY NAME, ADDRESS, SOCIAL SECURITY NUMBER, MEMBER ID NUMBER) except the following information about me:
____(DESCRIBE INFORMATION NOT TO BE DISCLOSED, IF ANY) for the purpose of helping me to resolve claims and health benefit coverage issue. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

This authorization is valid from the date of my / my representative's signature below and shall expire the earlier of ________________________________ (INSERT DATE/EVENT UPON WHICH THIS AUTHORIZATION EXPIRES) or the date my coverage ends with _______________________.

I understand that I have a right to revoke this authorization by providing written notice to ___________________________. However; this authorization may not be revoke if ___________________________, its employees or agents have taken action on this authorization prior to receiving the written notice. I also understand that I have a right to have a copy of this authorization.

I further understand that this authorization is voluntary and that I may refuse to sing this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage for services.

Name of Member: ____

Signature of Member: ____

Date: ____

If applicable, Legal Representative sign below:
By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Members behalf with respect to this authorization form

Name of Legal representative: ___________________________________

Signature of Legal Representative: _______________________________

Date: ____

Name of Witness: ____

Signature of Witness: ____