AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Section 1

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

GROUP HEALTH PLAN NAME: ____________________
GROUP NUMBER: ____________________
MEMBER'S NAME: ____________________
ADDRESS: ____________________
(Street, City, State, and Zip Code)
TELEPHONE NO: (area code) ____________________
EMPLOYEE OR SUBSCRIBER NAME: ____________________
SUBSCRIBER ID: ____________________

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 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.

Section 2

The following individual or organization is authorized to release my protected health information:

Meritain Health
Name of Individual(s), Provider(s), or Organization(s): *For example, Meritain Health*

Section 3

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, all information related to my plan.)

Section 4

The following Individual(s), Provider(s), or Organization(s) is authorized to receive my protected health information:

____
____
____

(Please list the specific names if possible, i.e. spouse, children, parents, etc)

Section 5

My protected health information will be used or disclosed for the following purpose(s):
At the request of the individual
____
____

(Describe the reason for each use and disclosure of the protected health information). If you do not wish to describe the purpose, you may indicate "at the request of the individual".

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 regulations, my protected health information described above may be re-disclosed and no longer be protected by federal privacy regulations.

I understand that I may refuse to sign this authorization. I further understand that my group health plan will not condition enrollment in the plan or eligibility for benefits on my signing this authorization.

I understand that I may revoke this authorization at any time by sending a written notification to the group health plan, 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 for information that already has used or disclosed, relying on this authorization.

This authorization expires: ___________________________, (list expiration date or event)
This authorization will expire at the termination of coverage, if no expiration date or event is listed

____ _____________________
Signature of Member or Personal Representative * Date

Print Name of Member or Personal Representative *

Description of Personal Representative's Authority

* This form should be signed by the member. If the member is unable to sign a Personal Representative may sign on their behalf; if the representative has the appropriate authority.

If the Group Health Plan/Business Associate is requesting authorization, the Group Health Plan/Business Associate must provide the individual with a signed copy of the authorization.

For Group Health Plan Use Only:

Submit copy of completed form to:
MERITAIN HEALTH
Attn: HIPAA Compliance Officer
P.O. Box 1671
Amherst, NY 14226-7671