



Authorization to Disclose Health Information

To: _____

From: _____
[Insert name of individual whose PHI is requested]

Date: _____

The purpose of this form is to authorize you to release certain medical information about me to the parties indicated below. I have described the information that I would like for you to release, and I understand that I will need to sign another form if my description is not broad enough to allow you to disclose all of the needed information. I have also indicated the reason I am requesting the disclosure and the people to whom the information should be released. I understand that if I authorize the release of information to a person or entity that is not subject to the federal privacy rules (HIPAA), the information may later be disclosed by that person or entity and may no longer be protected by the federal privacy rules. I understand that I can revoke this authorization by delivering a written statement of my written revocation to you. My revocation will be effective only on a prospective basis; it will not affect any actions you may already have taken in reliance on my authorization. I also understand that the Plan cannot require me to sign this authorization as a condition for enrollment in the Plan or for eligibility or payment of benefits.

The information requested is medical or claims payment information about:

(Describe information specifically, but broadly enough to serve its purpose.)

The individual(s) authorized to make this disclosure is (are):

(Name any person or class of persons who are permitted to disclose the information.)

The information may be disclosed to: _____
[Identify entity or person who can receive this information.]

I have requested this disclosure for the following purpose(s): _____

(List the reason for the disclosure. For example, if you want your spouse to be able to make claims inquiries, list that. Or, if you prefer, you may just state "at my request.")

This authorization will remain in effect until: _____

(You must indicate when the authorization will expire. You can give a date, or you may list an event that causes it to expire, such as "release from hospital.")

Signature

Date