HIPAA Release of Information
AUTHORIZATION FORM

I, _____ hereby authorize _____ and its affiliates, its employees and agents (collectively_____), to release to _____ **[Insert full name of person/organization]** my personal health information maintained by _____ which pertains to _____ _____ _____(e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me) **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 issues. 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 one year from the date on which it was signed.

I understand that I have a right to revoke this authorization by providing written notice to _____. However, this authorization may not be revoked if _____, it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization and a right to inspect or copy the health information to be used or disclosed.

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

Name: _____

Signature: _____

Date: _____

If applicable, Legal Representatives sign below:
By signing this form, I represent that I am the legal representative of the person 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 person's behalf with respect to this authorization form.

Name of Legal Representative: _____

Signature of Legal Representative: _____

Date: _____

Name of Witness: _____

Signature of Witness: _____