SelectHealth Advantage members:
P.O. Box 30196
Salt Lake City, UT 84130-0196
Phone: 855-442-9900 (toll-free)
Fax: 801-442-6580
selecthealthadvantage.org

All other SelectHealth members:
P.O. Box 30192
Salt Lake City, UT 84130-0192
Phone: 800-538-5038 (toll-free)
Fax: 801-442-6580
selecthealth.org

Authorization to Release Health Information

Form is not valid unless fully completed. Please return with a photocopy of the signer's government-issued photo ID.

I understand the following information:

1. Once SelectHealth® releases information according to this authorization, SelectHealth cannot guarantee that this information will not be re-released to a third party or that this information will be protected by federal and state law governing the use and disclosure of identifiable health information.
2. This authorization will remain in effect until it expires or until I revoke it in writing.
3. I may refuse to sign or may revoke this authorization at any time for any reason, unless SelectHealth has already made disclosures in reliance on this authorization.
4. While SelectHealth does not condition the beginning, continuation, or quality of health insurance, care management, and other services it provides to me on my signing and not revoking this authorization, refusing to sign or revoking this authorization may limit SelectHealth's ability to provide such services to me.
5. **For SelectHealth Advantage® members:** This signed authorization form does not give the individual named below the authority to initiate an appeal, grievance or prior authorization on my behalf. I must complete an additional form—Appointment of Representation—to grant that authorization.

In understanding the above, I agree to let SelectHealth share my information as described in this form. If I have questions, I can call SelectHealth. SelectHealth Advantage members call: 855-442-9900 (toll-free). All other SelectHealth members call: 800-538-5038 (toll-free). TTY users may call 711.

Member Information

First Name _____ Last Name _____

Member ID (on ID Card) _____ Street Address _____

City _____ State _____ ZIP _____

Ph# (_____) _____ Date of Birth _____ /_____ /_____
MM DD YYYY

SelectHealth may share information about the SelectHealth member named above (check one):

❑ For one year from the signature date ❑ For the length of the policy ❑ Until this date _____ /_____ /_____
MM DD YYYY

NOTE: *If an expiration date is not indicated, this authorization will stay active until one year from the signature date.*

The member's Information may be shared with the following person or organization (only one person or organization per form):

Name of person or organization _____ Date of Birth *(if person)* _____ /_____ /_____
MM DD YYYY

Street Address _____ Ph# (_____) _____

City _____ State _____ ZIP _____

Type of Information to be share (check the box(es) below to choose which information you would like shared).

❑ Enrollment
❑ Contact
❑ Existing prior authorization
❑ Existing appeal information
❑ Care management
❑ Claims payment
❑ All of the the above
❑ Other_____

SIGNATURE

_____ _____
Signature of member or legal representative Description of legal representative's authority

Date _____ /_____ /_____ ❑ **I have included a photocopy of the signer's government-issued photo ID.**
MM DD YYYY

SELECTHEALTH USE ONLY: ATTENTION MEMBER SERVICES

Password _____

Security Question _____

Security Question Answer _____