AUTHORIZATION FOR RELEASE OF RECORDS OR INFORMATION

SECTION A: I authorize the disclosure of my personal health information as described in Section B below. I understand this authorization is voluntary and made to confirm my directions. I hereby give my permission to the following Plan (_____) to disclose my personal health information in the manner described herein.

Name: _____

Address: _____

Telephone: _____

Member Number: _____

SECTION B: Personal Health Information to Be Disclosed: Specifically and meaningfully describe the personal health information you are authorizing to be used and/or disclosed:

_____

_____

_____

Persons/Entities Authorized to Receive and Use: Name or specifically describe the persons and /or entities to whom you are authorizing the plan named above to disclose or let use the personal health information described above:

_____ _____

Purpose of the Disclosure: The disclosure is being made for the following reason:

_____

Right to Revoke: I may revoke this authorization at any time except to the extent that action has been taken in reliance upon it. If I do not revoke it, this authorization will expire on (1) year after the date on which the authorization is signed. To revoke the authorization, I will contact **HIPAA Privacy Office, 10455 Mill Run Circle, Owings Mill, Maryland 21117, Mailstop: PMG-08.**

SIGNATURE:

I, _____, have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to the plan named above. I understand that, by signing this form, I am confirming my authorization that the plan named above may use and/or disclose to the persons and/or organizations named in this form the nonpublic personal health information described in this form.

Signature: _____ Date: _____

Witness: _____

If personal representative on behalf of the individual signs this authorization, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.
NOTICE TO RECIPIENT OF INFORMATION:

This information has been disclosed to you from records the confidentiality of which may be protected by Federal and/or State Law. If the records are so protected, Federal regulation (42 CFR Part 2) prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.