



**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".*





**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: ABC Company Employee Health Plan  
GROUP NUMBER: 1234  
MEMBER'S NAME: Joseph Smith *Name of the member who's information is the subject of this authorization*  
ADDRESS: 123 Main Street, Any Town, NY 14226  
(Street, City, State, and Zip Code)  
TELEPHONE NO: (area code) (716) 555-1234  
EMPLOYEE OR SUBSCRIBER NAME: Jennifer Smith  
SUBSCRIBER ID: 123-45-6789 or 123456789123

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:

All information related to my plan  
\_\_\_\_\_  
\_\_\_\_\_

*(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:

Jennifer Smith - Spouse  
Jack Smith - Son  
Jonathan Smith - Father

*(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 \*

**If signed by someone other than the member a description must be listed, i.e. Parent (if a minor), Power of Attorney (they must also submit a copy of this documentation (which must include access to Health Care Information))**

\_\_\_\_\_  
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*