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)

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.

SelectHealth members call: 800-5	38-5038 (toll-free). TTY users may c	all /11.	
Member Information			
First Name	Last Name		
Member ID (on ID Card)	Street Address		
City	S	tate	ZIP
Ph# ()	Date of Birth//_	YYYY	
	on about the SelectHealth member is date For the length of the policy		
	indicated, this authorization will stag		
organization per form)	shared with the following person or o		
City	State	ZIP	
Type of Information to be shared	(check the box(es) below to choose v	hich information	you would like shared).
☐ Enrollment☐ Contact☐ Existing prior authorization	Existing appeal informationCare managementClaims payment		e the above
SIGNATURE			
Signature of member or legal representation Date/ / / I had	entative Description of legare included a photocopy of the signer	al representative's 's government-iss	authority ued photo ID.
SELECTHEALTH USE ONLY: ATTENTIO			
Password Security Question			
Security Question Answer			