## **HIPAA Release of Information AUTHORIZATION FORM**

I, h	ereby authorize	and its	
affiliates, its employees and agents (c	ollectively	), to release to	
[Insert full name of person/organization] my personal health			
information maintained by	whic	ch 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 \_\_\_\_\_ [INSERT DATE/EVENT UPON WHICH THIS earlier of 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:	