NON MINOR DEPENDENT
AUTHORIZATION TO RELEASE HEALTH INFORMATION

Employee Name: _____

Employee Group Number: _____

Non-Minor Dependent's Name: _____ Birth Date: _____
MM / DD / YR

Address: _____

_____

_____

Dependent's Telephone Number (where best to contact Dependent): _____

Dependent's Identification Number and/or Social Security Number: _____

Parties Authorized to Receive / Use Dependent's Health Information:

_____ Birth Date: _____
MM / DD / YR

_____ Birth Date: _____
MM / DD / YR

- By signing this authorization form, I authorize HealthSCOPE Benefits to use and/or disclose my health information (information that constitutes protected health information as defined in the Privacy Rule of the Administration Simplification provision of the Health Insurance Portability and Accountably Act of 1996), to my spouse named above. I understand that I am under no obligation to sign this form, and that neither HealthSCOPE Benefits nor my health plan may condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.

I have signed this form voluntarily to document my wishes regarding the use and/or disclosure of the health information described below in Section 1 of this form.

1.Description of Health Information I Authorized to be Used or Disclosed.

The following is a specific description of the health information I authorized be used and/or disclosed: All health information pertaining to me that is in the possession of HealthSCOPE Benefits on behalf of my health plan.

2.Persons/Organizations Authorized to Use and/or Disclose My Health Information

I authorize the following person(s) and/or organization(s), including my Health Plan, to use and/or disclose the health information described above in Section 1 of this form: HealthSCOPE Benefits

3.Persons/Organizations Authorized to Receive and/or Use My Health Information

I authorize the custodial/noncustodial parent specifically named above to receive my health information regarding from HealthSCOPE Benefits and my health plan for the purposes listed below in Section 4 of this form. I understand that the named individual(s) is/are not Covered Entitites subject to federal privacy standards, and that the health information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards and that the above-named individuals may redisclose my health information without obtaining my authorization.

4.Description of Each Purpose for the Requested Use and/or Disclosure.

At my request, I authorize my health information to be used and/or disclosed to the custodial/noncustodial parent named above for any purpose.

5.Your Rights with Respect to This Authorization.

5.1 Right to Revoke. I understand that I have the right to revoke this authorization at any time. I also understand that my revocation of this authorization must be in writing. To obtain a copy of an authorization revocation form, I may contact my Plan Administrator at the address and telephone number contained in my Summary Plan Description. I am aware that my revocation will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) identified in Sections 2 and 3 of this form have already made in reliance upon this authorization.

5.2 Right to Receive Copy of This Authorization. I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of it.

6. Expiration of Authorization. This authorization shall be valid as long as the undersigned is covered under the health plan.

TO BE COMPLETED BY DEPENDENT:

I, _____(please print name), have had an opportunity to review and understand the contents of this form. By signing this form, I am confirming that it accurately reflects my wishes.

_____ _____

Dependent's Signature Date

Mail Completed Forms to:
HealthSCOPE Benefits
P. O. Box 3594
Little Rock, AR 72203-3594