AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION
Barnes Group Inc Medical Plan

This form is used to release your protected health information as required by federal and state laws. It must be completed in its entirety.

Your authorization allows the Health Plan to release your protected health information to a person or organization that you choose. You can revoke this authorization at any time by submitting a request in writing to the Health Plan. Revoking this authorization will not affect any action taken prior to receipt of your written revocation.

Member Information: (Individual whose information will be released)

Name (First, Middle, Last) _____ Date of Birth: (Month/Day/Year) _____

Address (including zip code) _____ Telephone Number: (including Area Code) _____

Group Name/Number: (If known) _____ Social Security Number (optional) _____ Member ID Number: _____

Health Plan: (organization that will release your information)

I authorize _____ to release my protected health information as described below.
(Health Plan name on your ID card)

Recipient: (Person or organization that will receive your information)

Person Name or Organization: _____ Telephone Number: (including area code) _____

Address: (including zip code) _____ Fax Number: (If available) _____

Description of the Information to be disclosed: (what type of information will be released)

____ Psychotherapy notes.
If this authorization is for psychotherapy notes you must not use it as an authorization for any other type of protected health information.

____ Other health information

Information to be used and/or disclosed: (specifically describe the protected health information to be used and/or disclosed – examples: "The claim related to my service on {date}"; "Appeal information related to my claim on {date}") _____

Purpose of Release of information: (examples – To resolve my appeal; to assist with my health insurance services; at my request) _____

No conditions: This authorization is voluntary. We will not condition your enrollment in a health plan, eligibility for benefits or payment of claims on giving this authorization.
Effect of Granting this Authorization: I understand that if the person or organization I authorize to receive the information described above is not subject to federal health information privacy laws, the protected health information used or disclosed may be subject to re-disclosure by the recipient, in which case it may no longer be protected under the HIPAA Privacy Rule.

Expiration: (when this authorization will end)

This authorization will expire on ___/___/____ (mm/dd/yyyy) or on the occurrence of the following event: (example: "When claim issue has been resolved.")

Approval: (you or your personal representative must sign and date this form in order for it to be complete)

I, _____, have had full opportunity to read and consider the contents of this authorization, and I understand that, by signing this form, I am confirming my authorization of the use and/or disclosure of my protected health information, as described in this form.

Signature of Member _____ Date _____

If this authorization is signed by a personal representative on behalf of the individual, complete the following. A copy of a Power of Attorney may be requested.

Printed Name of Personal Representative _____ Date _____ Telephone Number _____

Signature of Personal Representative _____ Relationship of Personal Representative _____