Authorization Form for Information Release

You may authorize your insurer in writing to share your health information with a third party such as a family member, employer, lawyer, broker or unrelated party by completing and submitting this authorization.

Please type or print neatly; we will not process incomplete or illegible forms.

1) I authorize: _____
(HEALTH INSURANCE PLAN/COMPANY)

2) To release the records of:

Member Name: _____ Date of Birth: _____

Membership Number: _____

Address: _____

Home Phone: _____ Work Phone: _____

3) Information to be released: (Check all that apply)

☐ Enrollment & Benefit Information

☐ Information Pertaining to an Appeal

☐ Claims/Explanation of Benefits Information

Include:

- ☐ Alcohol/Drug Treatment Information
- ☐ Mental Health Information

☐ Other: _____

4) Information may be released to:

A. Name of individual or organization: _____

Address: _____

City, State, Zip: _____

B. Name of individual or organization: _____

Address: _____

City, State, Zip: _____

C. Name of individual or organization: _____

Address: _____

City, State, Zip: _____

5) Reason for the release of information: (Describe the reason for each use and disclosure of the protected health information or indicate “at the request of the individual”)

_____

_____

Please read each of the following statements carefully before signing this document:

1. I understand that **this authorization will expire one year from the date signed** unless a shorter time frame is requested or a specific event has occurred.

*Date to expire (less than one year):*_____

After a specific event has occurred: _____
(e.g. after heart surgery or at the end of pregnancy)

2. I understand that this authorization is voluntary and is initiated at my request.

3. I understand that the released information may no longer be protected by federal privacy laws and may be re-disclosed by the individual or organization that receives the information.

4. I understand that I may refuse to sign this authorization. My health plan will not condition payment, enrollment, or eligibility of benefits on my signing this authorization.

5. I understand that I may revoke this authorization at any time by sending a written notification to Privacy Office at the address listed below 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: (i) for information that my health plan has already used or disclosed, relying on this authorization or (ii) if the authorization was obtained as a condition for coverage in my health plan and, by law, the health plan has a right to contest the coverage.

6. By signing this form, I revoke any *Authorization Form for Information Release* that I previously signed.

Signature: _____**Date:**_____

If the person signing this form is not the member or the parent/guardian of a dependent under the age of 18, you must attach a full copy of the official document indicating your legal authority to sign on behalf of the member (i.e. Power of Attorney, Court Assigned Guardian, Personal Representative, etc.)

Any mental health or substance abuse information, which has been disclosed from medical or other health care records, may be protected by federal and/or state law. If the records are so protected, Federal Regulation (42 CFR Part 2) prohibits the recipient of the information from making any further disclosure of this information unless such disclosure is expressly permitted by the written consent of the person to who it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Please mail or fax this authorization to:

Privacy Office
10455 Mill Run Circle
Owings Mills, MD 21117
Fax: 410-505-6692

Please keep a copy of the authorization for your records.