

# AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize \_\_\_\_\_ (name of Group Health Plan)

1. to disclose the following information (description of health information to be disclosed, for example, diagnosis, treatment, and insurance information): \_\_\_\_\_

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2. to \_\_\_\_\_  
(person/organization authorized to receive information)

3. for the purpose of \_\_\_\_\_  
(specific description of use of information, for example, to bill and obtain payment from a provider)

4. This authorization expires \_\_\_\_\_ (insert date or event related to the individual or the purpose of this authorization, for example, January 1, 2005 or two years after the last ambulance service provided.)

I have read and understand the following statement about my rights:

- I may revoke this authorization at any time in writing by sending a written request to \_\_\_\_\_ (name of person at group). I am aware that a revocation will not have any affect on any use or disclosure of protected health information by \_\_\_\_\_ (Group Health Plan) before it received the revocation.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive my health care benefits (enrollment, treatment or payment. In some cases this authorization will be required to obtain information necessary to process a specific claim).
- I understand that if protected health information about me is disclosed to a person or organization that is not required to comply with federal regulations, the information may me redisclosed and no longer protected by the federal privacy regulations.

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Signature of Employee, Spouse, or Dependent or Personal Representative

Date

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Printed Name of Employee, Spouse or Dependent

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Name of Personal Representative (if applicable)

Relationship of Personal Representative to  
Employee, Spouse, or Dependent