

Authorization for the Use and Disclosure of Individually Identifiable Health Information

PURPOSE: This form is used to request an individual's authorization for the use and disclosure of individually identifiable health information.

SECTION A: Individual Granting Authorization

Covered Employee's Name: _____ Employee's SSN: _____-_____-_____

Covered Employee's Employer: _____ Current Phone: _____-_____-_____

Name of Individual Making Request: _____ Individual's SSN: _____-_____-_____

Current Address: _____

SECTION B: Descriptions

1. Specific description of information that may be used / disclosed: _____

2. The information will be used / disclosed for the following purpose(s): _____

3. Persons / organizations authorized to use or disclose the information _____

4. Persons / organizations authorized to receive the information _____

5. Will the persons / organizations authorized to use / disclose the information receive compensation for doing so?

Yes

No

6. I 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 enrollment, payment for or coverage of services, or ability to obtain treatment, except as provided in this form.

7. If the purpose of this authorization is for my claims administrator to determine eligibility before enrollment, the requested use or disclosure is not for psychotherapy notes, and I refuse to sign this authorization, my claims administrator reserves the right to deny enrollment or eligibility for benefits.

8. If the purpose of this authorization is to disclose health information to another party based on health care that is provided solely to obtain such information, and I refuse to sign this authorization, my claims administrator reserves the right to deny that health care.

