

**AUTHORIZATION FORM**  
(INDIVIDUAL AUTHORIZATION FOR USE AND DISCLOSURE OF  
PROTECTED HEALTH INFORMATION)

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**EMPLOYEE BENEFIT PLAN**

With regard to the Plan named above and by my signature below, I authorize the disclosure of the Protected Health Information identified below.

**PATIENT'S NAME:** \_\_\_\_\_

**INFORMATION TO BE DISCLOSED:**(insert description of health information to be disclosed (e.g., patient's diagnosis, treatment or coverage information))

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**PURPOSE OF THE DISCLOSURE:**(describe all purposes for the disclosure. Not required if information is to be disclosed only to the Plan participant)

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**PHI TO BE DISCLOSED BY:**

**PHI TO BE DISCLOSED TO:**

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**ACKNOWLEDGEMENTS**

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my eligibility for Plan benefits or my ability to obtain treatment or payment.

If this authorization is for the Plan's eligibility or enrollment determinations related to me or for underwriting or risk rating determinations, I understand that I may refuse to sign this authorization but that, if I do not sign, the Plan may refuse to enroll me.

I understand that I may revoke this authorization, at any time, by sending a written request to the privacy contact identified below. I am aware that a revocation will not have any affect on any use or disclosure of Protected Health Information (PHI) by the Plan before it receives the revocation. The privacy contact is:

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This authorization expires on \_\_\_\_\_.

I understand that if Protected Health Information about me is disclosed to a person or organization that is not required to comply with federal privacy regulations, the information may be redisclosed and is not protected by the federal privacy regulations.

**SIGNATURE OF PATIENT** (or parent if a minor or patient's personal representative – see NOTE)

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Signature

Date

NOTE: If this authorization is signed by the patient's personal representative, attach a statement of the representative's authority to act on behalf of the individual.