Clear Form

Authorization to Release Protected Health Information

If you have questions or need assistance completing this form, we're happy to help; just give us a call at the number on the back of your ID card.

Member's Information

Last Name	***First Name***		***MI***
HPI Member ID #	***Social Security # (optional)***		***Date of Birth***
Home Address	***City***	***State***	***Zip***

Information Being Requested

As detailed below, I hereby authorize Health Plans, Inc. (HPI), as Claims Administrator of my Employee Health Benefit Plan, to ***release*** my Protected Health Information to the "Person(s)" indicated to be used for the purpose indicated.

Protected Health Information to release (Be specific, including types of information and dates.)	
Name of "Person(s)" receiving Protected Health Information	
Role of "Person(s)"	
Address of "Person(s)"	
Purpose ("at my request" is a sufficient answer)	

TERMS OF THIS AUTHORIZATION

1. I understand that my Employee Health Benefit Plan will not condition my treatment, enrollment or eligibility for health insurance benefits on my signing of this Authorization.
2. I understand that Health Plans will not use or re-disclose the Protected Health Information obtained for any purpose not indicated on this Authorization.
3. I understand that if my Protected Health Information is to be received by individuals or organizations that are not covered by federal privacy regulations, my Protected Health Information may be re-disclosed and no longer protected by federal privacy regulations.
4. I understand that I have a right to receive a copy of this Authorization upon request.
5. I understand that I may revoke this Authorization in writing at any time.
6. I understand that this Authorization will remain in effect until the following date or event, or until I revoke this Authorization in writing: ☐

I have read and understand the terms of this Authorization and I hereby authorize the use and release of my Protected Health Information in the manner described in this Authorization.

Printed Name _____ *Signature** _____ *Date* _____

*This Authorization will only be valid if it is signed by the member, the legal guardian of a member that is a minor, or by an individual that has a Designated Personal Representative form on file for this member. If you are not the member, please indicate your relationship to the member.

☐ Legal guardian of the minor member. Relationship to minor: ☐

☐ Designated Personal Representative.

Please return this completed form to the attention of the Claims Department at the address below.

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