



AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the use/disclosure of protected health information about me as described below.

Enrollee Name: _____

ID Number: _____

Enrollee Date of Birth: _____

Group Number: _____

1. Person(s) or class of persons authorized to use/disclose the information:

2. Person(s) or class of persons authorized to receive the information:

3. Specific description of the information that may be used/disclosed, including the dates:

4. The information will be used/disclosed for the following purposes:¹

5. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by the federal privacy regulations, the information described above may be re-disclosed by the recipient and no longer protected by these regulations. However, if my authorization is for use/disclosure of substance abuse information, I understand that the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

6. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my health care treatment or the payment of my health care treatment. I may inspect or copy any information used/disclosed under this authorization.

7. I understand that I may revoke this authorization **in writing** by notifying the AultCare Privacy Coordinator, except to the extent that action has been taken in reliance on this authorization.

8. **This authorization expires:** _____ [*State Law mandates that Authorizations for the Release of Information are limited to 12 months, unless an earlier date is requested. If no date is entered, form will automatically expire upon 12 months.*].

Signature of enrollee or enrollee's representative

Date

Printed name of enrollee's representative: _____

Relationship to the enrollee: _____

(A copy of this signed form will be provided to the enrollee.)

**** YOU MAY REFUSE TO SIGN THIS AUTHORIZATION ****

¹ You do not need to fill out this section if disclosure is requested by the enrollee, except if the information to be disclosed is covered under the Federal Substance Abuse Confidentiality Requirements.