HEALTH Advocate™

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AUTHORIZATION FOR USE AND DISCLOSURE OF PRIVATE HEALTH INFORMATION

DESCRIPTION OF PHI TO BE **RELEASED** TO ***HEALTH ADVOCATE:***

I hereby authorize my health plan(s), my healthcare providers and their applicable business associates to disclose the following Private Health Information ("PHI") pertaining to me: enrollment, claims, payment and managed care information to Health Advocate, Inc. for the purpose of assisting me in my quest to obtain health care services and/or approval or payment for health care services.

Unless otherwise indicated, my authorization includes the release of the following: (*Please strike through those you wish to exclude, if any.)*

- Diagnosis and/or treatment for alcoholism and/or drug abuse or dependency
- Diagnosis and/or treatment regarding mental health issues
- HIV antibody test results and/or diagnosis and treatment
- Genetic test results and/or related treatment

Identification of person authorizing release: *(Please complete all items.)*

Name of Member/Participant: _____ (Last) _____ (First) _____ (MI)

SSN: _____ **Date of Birth:** _____ **Relationship to Subscriber:** _____

Address: _____ (Street (Apt #)) _____ (City) _____ (State) _____ (Zip)

Subscriber Name: _____ **SSN:** _____

Subscriber's Sponsor Name: *(eg: Employer, Health & Welfare Fund)***:** _____

Health Insurance Carrier 1: _____ **Health Insurance Carrier 2:** _____

Carrier 1 – Coverage Type: ☐ **HMO** ☐ **POS** ☐ **PPO** ☐ **Indemnity** ☐ **Medicare ID#:** _____

Carrier 2 – Coverage Type: ☐ **HMO** ☐ **POS** ☐ **PPO** ☐ **Indemnity** ☐ **Medicare ID#:** _____

Unless otherwise revoked, this authorization will commence on the date indicated below and will expire on the following date, event or circumstance: _____. If I fail to specify, this authorization will expire in twelve months.

- I understand that information used or disclosed based on this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.
- I understand that I may revoke this authorization at any time by giving written notice of my revocation to Health Advocate's Privacy Officer at the above address. I understand that revocation of this authorization will not affect any action Health Advocate or other parties took in reliance on this authorization before it received my written notice of revocation.
- I understand that Health Advocate provides administrative and informational services only and does not provide health insurance or medical services nor does it recommend treatment. Consequently, independent health care practitioners, who are not employees or agents of Health Advocate, will provide all my medical services.

Signature: _____ **Date:** _____

Signature: _____ **Date:** _____
Personal Representative (Include a description of such authority to act for the patient.)

You are not required to authorize Health Advocate to have access to your "PHI" and the provision of treatment, payment, enrollment or eligibility for benefits does not depend on whether you sign this authorization. You should keep a signed copy of this authorization for your records, however, a copy of this signed authorization will be provided upon your request.