

Authorization for Release of Personal and Health Information



Member Name: _____ Address: _____

Contract Number: _____ City/State/Zip: _____

Date of Birth: _____ Member Phone Number: _____

I request and authorize Priority Health/Priority Health Managed Benefits, Inc./Priority Health Insurance Company/Priority Health Government Programs, Inc. ("Priority Health") to release my personal and health information that Priority Health has which may include claims and billing information, medical records created by medical practitioners that Priority Health received, including records regarding general medical care, alcohol and drug abuse treatment, psychological or psychiatric treatment, social services counseling, human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) or AIDS related complex (ARC), communicable diseases or infections, venereal diseases, tuberculosis and hepatitis, and demographic information. I understand that Priority Health will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

A. Information to be disclosed (check **one** box only):

- All of my personal and health information, including medical records
- Only claims and billing information
- Other (such as a specific date of service or information pertaining to a specific issue): _____

B. Disclosure is to be made to (name of person or entity, address, zip code, and phone number):

C. Purpose of the disclosure:

- At the request of the Individual
- Other: _____

D. This authorization expires (check **one** box only):

- On the following date: _____
- Upon the following event: _____

I understand that I may refuse to sign this authorization and that I may revoke it at any time but I must do so in writing to Priority Health, at the address listed below. The revocation will not be effective to the extent that Priority Health has already disclosed the information. I understand that I have the right to receive a copy of this authorization after it is signed if Priority Health requested it. I understand that the persons to whom information is disclosed under this Authorization may possibly re-disclose the information to others without my knowledge or consent and therefore the privacy of my personal and health information may no longer be protected by law.

Signature

Date Signed

If signed by a person other than the member, please check the relationship and authority to do so:

- Parent of Minor Child
- Personal Representative of Deceased Person
- Power of Attorney
- Legal Guardian
- Member is mentally competent, but physically unable to sign and has verbally asked or physically demonstrated a request for the above signer to sign on the member's behalf.

Witnessed by: _____ Date: _____

Please mail form to: Priority Health, MS: 2005; 1231 East Beltline, NE; Grand Rapids, MI 49525-4501
Or, fax to: 616 942-0616