

Authorization for release of personal and health information



A. Member whose information is to be released

Member name		Date of birth: _____ / _____ / _____
Address		
City	State	ZIP code
Contract number (on ID card)	Phone	

I request and authorize Priority Health* to release my personal and health information. This may include claims and billing information. It may also include medical records that Priority Health has received from medical practitioners, 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, hepatitis and demographic information. (* "Priority Health" includes Priority Health/Priority Health Managed Benefits, Inc./Priority Health Insurance Company/Priority Health Government Programs, Inc.)

B. Type of information Priority Health may release (check ONE box)

All of my information (including personal, health, demographic, claims, billing and medical records); **OR**
 Only my claims and billing information; **OR**
 Other, such as information regarding a specific date of service or issue (explain): _____

C. Who may receive your information?

Individual/entity name		Phone
Address		
City	State	ZIP code

D. What is the purpose of this Authorization? (check ONE box)

At my request
 Other (explain): _____

E. When will this Authorization expire? (check ONE box)

Note: If I fail to list an expiration date or event below, this authorization will expire one year from the date signed.

No expiration
 Upon my coverage termination
 On the following date: _____ / _____ / _____ (MM/DD/YYYY)
 Upon my death
 Upon my written revocation
 On the following event: _____

I understand that I may refuse to sign this Authorization. I may revoke this Authorization at any time by notifying Priority Health in writing at the address listed below. The revocation will not be effective for information that Priority Health discloses between the time that this Authorization is signed and when the revocation is received. If Priority Health requested this Authorization, I understand that I have the right to receive a copy of this Authorization after I sign it. I understand that Priority Health will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization. I understand that the persons to whom information is disclosed under this Authorization may possibly redisclose 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.

F. Signature required

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

Parent of a minor child
 Power of attorney
 Legal guardian
 Personal representative of deceased member

Signature	Date _____ / _____ / _____
Printed name	

G. Finalize and send

- Form must be fully completed
- Submit form via one of the following
 - Scan and email to HIPAA@priorityhealth.com
 - Fax to: 616 942-0616
 - Mail to: Priority Health, MS 2005, 1231 East Beltline, N.E., Grand Rapids, MI, 49525-4501