

# Authorization for release of personal and health information



## A. MEMBER WHOSE INFORMATION IS TO BE RELEASED

Member name		Member date of birth	Contract number (on your membership card)	
Street address		City	State	ZIP
Phone number that we may use you contact you <input type="checkbox"/> Landline (home phone) <input type="checkbox"/> Cell phone	Alternate number that we may use to contact you (optional) <input type="checkbox"/> Landline (home phone) <input type="checkbox"/> Cell 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				
Street address		City	State	ZIP
Primary phone number <input type="checkbox"/> Landline (home phone) <input type="checkbox"/> Cell phone	Alternate number (optional) <input type="checkbox"/> Landline (home phone) <input type="checkbox"/> Cell phone			

## 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	Printed name	Date
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## G. FINALIZE AND SEND

- Form must be fully completed
- Submit form via one of the following:
  - Scan and email to [HIPAA@priorityhealth.com](mailto:HIPAA@priorityhealth.com)
  - Fax to: 616.942.0616
  - Mail to: Priority Health, MS 2005, 1231 East Beltline, N.E., Grand Rapids, MI, 49525-4501

*This form satisfies all required elements of a valid authorization under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).*