AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Participant Name:_____ Social Security Number: _____

Address: _____

_____

Home Telephone Number: _____ Work Telephone Number: _____

E-mail Address: _____ Participant Birth Date: _____

By signing this authorization form, I authorize disclosure of my health information (information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996) in the manner described below. **I understand that I am under no obligation to sign this form and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.**

I have signed this form voluntarily to document my wishes regarding the use and/or disclosure of the health information described below in Section 1 of this form.

1. **Description of Health Information I Authorize to be Used or Disclosed.**
   The following is a specific description of the health information I authorize be disclosed: (Specify and provide a meaningful description.)

   _____

   _____

   _____

2. **Persons/Organizations Authorized to Receive and/or Disclose My Health Information.**
   I authorize the following person(s) and/or organization(s) (or classes of persons and/or organizations) to receive my health information and to use or disclose such information for the purposes listed below in Section 4 of this form. I understand that if the person(s) and/or organization(s) listed below are not health care providers, health plans or health care clearinghouses subject to federal privacy standards, the health information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards and such person(s) and/or organization(s) may redisclose my health information without obtaining my authorization.

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