

# Authorization Form for Information Release

You may authorize your insurer in writing to share your health information with a third party such as an employer, lawyer, individual broker or unrelated party by completing and submitting this authorization.

**Please print neatly to ensure correct processing and to prevent any delays in service.**

## **1 I, The Undersigned, Authorize:**

Name of Health Plan: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

## **2 To Release Information from the Records of:**

Member Name: \_\_\_\_\_

Member Date of Birth: \_\_\_\_\_

Social Security/Member Number: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

## **3 Information Authorized for Release: (check all that apply)**

\_\_\_\_\_ Claims/EOB Information \_\_\_\_\_ Enrollment & Benefit Information

\_\_\_\_\_ Information pertaining to an Appeal \_\_\_\_\_ Mental Health Records

\_\_\_\_\_ Alcohol & Substance Records \_\_\_\_\_ Premium Payment Information

\_\_\_\_\_ Other: \_\_\_\_\_

(please specify date of service, provider name)

## **4 Information may be Released to:**

A. Name of Individual or Organization: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_

B. Name of Individual or Organization: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_

## 5 The Information Will be Used or Disclosed for the Following Purposes:

(Describe the reason for each use and disclosure of the protected health information. If you want the information for your own purposes insert "at the request of the individual.")

1. I understand that this authorization will expire one year from the date signed unless a shorter time frame is requested or specific event has occurred.

Date to expire (can not exceed one year from date signed): \_\_\_\_\_

Specific event has occurred (e.g. after heart surgery or end of pregnancy) \_\_\_\_\_

2. I understand that this authorization is voluntary and being made at my request.

3. I understand that the released information may no longer be protected by federal privacy laws and may be redisclosed by the individual or organization that receives the information.

4. I understand that I may refuse to sign this authorization. My health plan will not condition payment, enrollment or eligibility of benefits on my signing this authorization.

5. I understand that I may revoke this authorization at any time by sending a written notification to the Privacy Office at the address listed below, and this revocation will be effective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective: (i) for information that my health plan has already used or disclosed, relying on this authorization or (ii) if the authorization was obtained as a condition for coverage in my health plan, and, by law, the health plan has a right to contest the coverage.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If the person signing this authorization is not the member, please provide your full name and relationship to the member. Please attach a full copy of the official document indicating you are the legally designated Power of Attorney, Court Assigned Guardian, Personal Representative, etc., of the member.

\_\_\_\_\_  
Print Your Full Name and Relationship to Member

### Please mail or fax this authorization to:

CareFirst Privacy Office  
10455 Mill Run Circle, TBP-06  
Owings Mills, MD 21117  
Fax: 410-505-6692

**Please keep a copy of the authorization.**

**We will provide you with a signed a copy of this authorization upon request.**

Any mental health or substance abuse information, which has been disclosed from medical or other health care records, may be protected by federal and/or state law. If the records are so protected, Federal Regulation (42CFR Part 2) prohibits the recipient of the information from making any further disclosure of this information unless such disclosure is expressly permitted by the written consent of the person to who it pertains, or as otherwise permitted by 42CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.