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Fort Wayne IN 46801
Telephone: (260) 435-7509
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Administrative Services

Authorization for Release of Information

Name of Member/Participant whose information will be disclosed	☐ Member's ID# ☐ SSN	Date of Birth

Street Address	City	State	Zip Code

I understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the Federal privacy regulations.

I further understand that by signing below, I am authorizing the release or exchange of group health plan information, including eligibility, benefits, and claim information, to the parties named below.

I understand that I may revoke this authorization at any time by notifying MedPartners in writing. I understand this release will remain valid and in full effect until such time that it is revoked in writing.

I hereby authorize MedPartners to (check all that apply):

☐ Exchange information with the parties I have indicated below
☐ Release information to the parties I have indicated below
☐ Obtain information from the parties I have indicated below

I hereby authorize MedPartners to exchange/release/obtain information:

☐ verbally only
☐ in written form only
☐ both verbally and in written form

Name of Person receiving/communicating the information to:

Name	SSN	Date of Birth

Street Address	City	State	Zip Code

Phone Number: (_____) _____ Extension _____

Signature of Member/Participant, Personal Representative, Parent/Guardian who is authorizing the Release	Date