

## Authorization Form for Release of Records and Information

### COMPLETE SECTION A:

#### A. Identification

This document authorizes the use and/or disclosure of confidential protected health information about the following person:

Employee:

Address:

Employee/Retiree Date of Birth: \_\_\_\_\_

Daytime Phone Number: (        ) \_\_\_\_\_

Employee Social Security/Contract Number: \_\_\_\_\_

Name(s) of Member(s), If other than Employee/Retiree (your Spouse and/or Dependent Children), about whom information may be used and/or disclosed:

\_\_\_\_\_  
\_\_\_\_\_

#### B. Directions for Release

This authorization applies in accordance with my directions as checked below. I authorize the individual or company identified below in Section B.1b to release and/or use protected health information pertaining to the member(s) listed in Section A to the individual or company identified in Section B.1a. I understand that the information to be disclosed and/or used may include enrollment information, eligibility information, premium (payment) information, claims records, claims status, and patient management records, according to my directions.

#### CHECK ALL THAT APPLY IN SECTIONS B.1a AND B.1b:

##### B.1a. I authorize the disclosure of information to:

Benefits Review Committee

Employee Benefits Division

My Medical Plan (Name): \_\_\_\_\_

My Dental Plan (Name): \_\_\_\_\_

My Prescription Plan (Name): \_\_\_\_\_

My Physician/Provider (Name): \_\_\_\_\_

My Legal/Personal Representative (Name or describe): \_\_\_\_\_

Other (Name or describe): \_\_\_\_\_

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**B.1b. I authorize the obtaining of information from:**

- Benefits Review Committee
- Employee Benefits Division
- My Medical Plan (Name): \_\_\_\_\_
- My Dental Plan (Name): \_\_\_\_\_
- My Prescription Plan (Name): \_\_\_\_\_
- My Physician/Provider (Name): \_\_\_\_\_
- My Legal/Personal Representative (Name or describe): \_\_\_\_\_
- \_\_\_\_\_
- Other (Name or describe): \_\_\_\_\_

**CHECK ALL THAT APPLY IN SECTION B. 2:**

B.2. I authorize the disclosure and/or use of the following information:

- (a) any information related to a specific claim (specify date of service or type of treatment): \_\_\_\_\_
- (b) my entire medical record
- (c) my enrollment, eligibility and premium payment records
- (d) Other (describe information in detail): \_\_\_\_\_

**CHECK ALL THAT APPLY IN SECTION B.3:**

B.3. I authorize the disclosure and/or use for the following reason(s):

- (a) for review and appeal of a claim denial
- (b) for assistance with my plan coverages and benefits
- (c) for assistance with my dependent's plan coverages and benefits
- (d) for my own purposes
- (e) Other (describe purposes in detail): \_\_\_\_\_

**READ SECTION C:**

**C. Right to Revoke:**

I understand that I may revoke this Authorization at any time except to the extent that action has already been taken in reliance upon it. If I do not revoke it, this Authorization will expire one (1) year after the date on which the Authorization is signed. To revoke the Authorization, I understand I must contact the following in writing: Employee Benefits Division, HIPAA Privacy Officer, Room 510, 301 W. Preston Street, Baltimore, MD 21201, or via fax to 410-333-7104.

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**YOU MUST SIGN IN SECTION D:**

**D. Authorization and Signature:** I authorize the release of my confidential protected health information, as described in my directions in Section B. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is covered by Maryland law which prohibits redisclosure or other laws that limit the use and/or disclosure of my confidential protected health information. My treatment, payment, enrollment and eligibility are not conditioned on signing this authorization but the information authorized may be necessary for claim review and appeal purposes.

I, \_\_\_\_\_, have read the contents of this Authorization, and I confirm that the contents are consistent with my directions. I understand that by signing this form, I am authorizing the use and/or disclosure of my confidential protected health information.

\_\_\_\_\_  
Your Signature

\_\_\_\_\_  
Date

**Complete, Sign and Return this form along with copies of any or all receipts, explanation of benefit(s) or any other pertinent claim information to: Sterling Benefits Group, 5324 Ivan Drive, Lansing, MI 48917 Fax: 517-886-2033**