HealthMarkets℠
Keeping the Promise of Affordable Coverage
Administrative Services Group

AUTHORIZATION FROM INDIVIDUAL

Purpose: This form is used to confirm the direction of an individual that our Company use or disclose protected health information for a particular purpose. Subsequent requests will require a new authorization. **PLEASE RETAIN A COPY FOR YOUR RECORDS**.

SECTION A: Psychotherapy Notes.

☐ Check if this authorization is for psychotherapy notes.

If this authorization is for psychotherapy notes, you must *not* use it as an authorization for any other type of protected health information.

SECTION B: The Individual (or the Individual's Personal Representative) confirming the authorization.

I authorize the use and/or disclosure of my protected health information as described in Section C below. I understand this authorization is voluntary and made to confirm my direction.

I understand that, if the persons or organizations I authorize below to receive and/or use the protected health information described below are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

Name: ______________________________

Address: ______________________________

Telephone: ____________________ E-mail: ____________________

Health ID Number: ____________________ (located on Health ID Cards or Policy/Certificate)

SECTION C: The use and/or disclosure being authorized.

Protected Health Information (PHI) to Be Used and/or Disclosed: Describe in detail the PHI you are authorizing be used and/or disclosed:

____

____

____

Entities Authorized to Receive: Name or specifically describe the persons and/or organizations (or the classes of persons and/or organizations) to whom you are authorizing our Company to disclose the PHI described above:

____________________ ____________________

____________________ ____________________

____________________ ____________________

SECTION D: Expiration and Revocation.

Expiration: This authorization will expire (complete one):

☐ On ____/____/_________ (Specific Date)

☐ On occurrence of the following event (which must relate to the individual or to the purpose of the use and/or disclosure being authorized):

____

____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation. I understand that revocation of this authorization will *not* affect any action you took in reliance on this authorization before you received my written notice of revocation.

SIGNATURE OF INDIVIDUAL OR INDIVIDUAL'S PERSONAL REPRESENTATIVE

I, ____, have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to the Company. I understand that, by signing this form, I am confirming my authorization that the Company may use and/or disclose to the persons and/or organizations named in this form the Protected Health Information described in this form.

Signature: ___________________________________ Date: __________________________

If this authorization is signed by an individual personal representative on behalf of the individual, complete the following:

Personal Representative's Name: ____

Relationship to Individual: ____

By: ______________________ ________________________

Date

State of: ________________________

County of: ________________________

Subscribed and sworn to before me this _______ day of ____________________.

Notary Public: ________________________

Print Name ________________________

My commission expires: ________________.