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.

   _____

   _____

   _____

3. Description of Each Purpose For the Requested Use and/or Disclosure.
I authorize my health information to be used and/or disclosed for the following specific purposes:

_____

_____

_____

4. Your Rights With Respect to This Authorization.

4.1 Right to Revoke. I understand that I have the right to revoke this authorization at any time by submitting my revocation in writing. I also understand that my revocation of this authorization must be in writing. I am aware that my revocation will not be effective as to uses and/or disclosures of my health information that person (s) and/or organization(s) identified in Section 2 of this form have already made in reliance upon this Authorization.

4.2 Right to Receive a Copy of This Authorization. I understand that if I agree to sign this Authorization, which I am not required to do, I must be provided with a signed copy of it.

5. Expiration of Authorization.
This Authorization will expire (choose and complete one):

☐ On ____/____/____
MM / DD / YR

☐ Upon the occurrence of the following event(s) related to my health care or to the purpose(s) for which I have authorized the use and/or disclosure of my health information described in Section 3 of this form:

_____

_____

_____

I, _____(please print name), have had an opportunity to review and understand the contents of this form. By signing this form, I am confirming that it accurately reflects my wishes.

_____ ____/____/____
Participant Signature *Date*

If this Authorization is to be signed by a personal representative, that personal representative must also complete page 3 before the form is submitted to the MPI Health Plan.

If this Authorization is to be signed by a personal representative, complete the following:

Name of personal representative: *(Please print)* _____

Relationship to Participant or nature of authority (e.g., health care power of attorney, guardian, other statutory authorization): _____

_____

Address: _____

_____

Home Telephone Number: _____ Work Telephone Number: _____

E-mail Address: _____

_____ ____/____/____
Signature of Personal Representative *Date*