AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(Shaded areas denote required fields):
TO: *(insert name of benefits administrator or provider who you are requesting to release information):*
_____
_____
Indicate applicable GE Health Plan: HCP:____GEMB: ____ Other (insert name): _____

Name of individual authorizing use or disclosure: _____ _____
Subscriber ID/SSN#: _____
Address: _____ _____
Telephone #: (____)_____-_____Fax # (____)_____-_____ Cell Phone #(____)_____-_____

I authorize the use or disclosure of the above-named individual's information as described below. *Check all that apply:*

- ❑ Any and all records including mental health, HIV/AIDS, genetic testing and/or substance abuse records. (*Cross out any item you do not authorize to be released)*
- ❑ Records regarding treatment for the following condition or injury _____ _____ on or about _____
- ❑ Records covering the period of time _____ to _____
- ❑ Other (Please specify and include dates)_____ _____

This information may be disclosed to, and used by, the following individuals or organizations:
Name: _____
Address: _____
Name: _____
Address: _____

Please indicate the purpose(s) for this release of information. *Check all that apply:*

☐ Enrollment information ☐ Benefit or Coverage information ☐ All claims information
☐ All services from a specific health care provider (List provider's name): _____
☐ For the following purposes:
_____

- This authorization is voluntary.
- I may revoke this authorization at any time by notifying in writing the company/individual listed above from providing the information identified in this authorization, but if I do revoke this authorization, it won't have any affect on any actions taken before my revocation was received.
- I would like this authorization to expire on (enter date): _____/_____/_____
  (If no expiration date is provided, this authorization will expire twelve (12) months from the date of receipt)
- Payment, enrollment or eligibility for benefits for my health care will not be affected if I do not sign this form.
- Information disclosed as a result of this authorization may no longer be protected by federal privacy laws and may be disclosed by the company or individual receiving the authorization.
- I should retain a copy of this authorization form.

Signed:_____Print Name:_____Date:_____
Signature of individual, parent on behalf of minor or legal representative

If signed by a legal representative, relationship to individual: _____
Please provide representative documentation, i.e. Power of Attorney, Health Care Surrogate or Guardianship papers