AUTHORIZATION TO NAME A PERSON TO OBTAIN PERSONAL HEALTH INFORMATION

INDIVIDUAL DATA:

MY NAME: _____

MY GROUP HEALTH PLAN ID NUMBER: _____

MY ADDRESS: _____

_____

MY TELEPHONE NUMBER: _____

I authorize the below named individual(s) to obtain/to be given Personal Health Information (PHI) regarding my health care claims. I understand that this consent will allow this person(s) to discuss my claims concerning my health care.

I give authorization to: _____

I understand that this authorization can be revoked or changed at any time, and that the revocation or change must be done in writing.

This authorization will remain in effect for 6 years from the date it is signed, unless I revoke it earlier.

_____

Signature of plan participant. Date