

**Authorization To Disclose Protected Health Information**  
(ALL INFORMATION MUST BE COMPLETED FOR AUTHORIZATION TO BE VALID)

**I authorize the disclosure of protected health information (as defined by 45 CFR §160.100) regarding, or related to:**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ I.D. No.: \_\_\_\_\_

**I authorize the disclosure of the following information:**

- My insurance information, including my claims
- Other: \_\_\_\_\_

**I authorize the following individual or entity to receive the information authorized herein:**

\_\_\_\_\_

**I authorize the following individual or entity to disclose the information authorized herein:**

- IHC Health Solutions
- Other: \_\_\_\_\_

**The purpose of the authorized disclosure is:**

- Permit my spouse to participate in the administration of my insurance coverage.
- Permit my parent(s) to participate in the administration of my insurance coverage.
- Other: \_\_\_\_\_

**This authorization shall expire as of the following date or event: (YOU MUST COMPLETE THIS SECTION OR AUTHORIZATION WILL BE RETURNED TO YOU)**

- Until revoked.
- Until the following date: \_\_\_\_\_
- Until the following event: \_\_\_\_\_

I specifically authorize the release of medical records or information, if any, related to the diagnosis, treatment, and prognosis regarding any mental condition and/or treatment (excluding psychotherapy notes); drug or alcohol abuse and/or treatment; or HIV or AIDS or AIDS related complex condition and/or treatment.

I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization.

I understand that unless otherwise noted herein, treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.

I understand that there is a possibility of redisclosure to the extent that I authorize information to be disclosed to a person or entity not regulated by the Standards for the Privacy of Individually Identifiable Health Information published by the United States Department of Health and Human Services at 45 CFR §§160 and 164.

A photocopy of this Authorization shall be as valid as the original.

**Signature of Individual or Individual's Personal Representative:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**If signed by the individual's personal representative, describe your authority to sign on behalf of the individual (must complete for authorization to be valid):**

- Parent
- Court appointed legal guardian
- Power of Attorney
- Other: