



MEMBER AUTHORIZATION FORM

Authorization for Use or Disclosure of Information

This Authorization for use or disclosure of Personal Health Information (PHI) is being requested by (member name) _____ to comply with the terms of Federal HIPAA Privacy Rules . A copy of this form is as valid as the original.

This form must be completed and signed by the member in order to enable a HealthPass representative to discuss your coverage with the designee(s). I (member name) _____ hereby authorize the use or disclosure of personal health information as described below. As the member, I (print name) _____ authorize the following designee(s) _____ (print name(s)) to discuss personal health information with a HealthPass representative.

Unless otherwise revoked, this authorization will commence on the date indicated below and will expire on the following date, event or circumstance: _____ . If I fail to specify, this authorization will expire when coverage is terminated.

Member (Print Name)

Member (Signature)

Designee 1 (Print Name)

Designee 2 (Print Name)

Date

