



# 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