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) 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