AUTHORIZATION TO USE & DISCLOSE PROTECTED HEALTH INFORMATION

Except as otherwise permitted or required by applicable federal and state laws and regulations, Advocacy must obtain an authorization before using or disclosing protected health information ("PHI"). Upon receipt of a valid authorization for its use and/or disclosure of PHI, Advocacy will make such use and/or disclosure in a manner consistent with such authorization.

First: _____ Last: _____ MI: _____ ____/____/____

Legal Name ***Date of Birth***

_____

Address ***City*** ***State*** ***Zip***

Phone _____

	Insurance Company *(ex. Aetna)*	**Customer Service Phone Number** *(back of your insurance card)*	**Group #**	**Member ID #**
Medical				
Dental				
Vision				

Description of PHI to be used or disclosed (check all that apply):

- ☐ For Health Plan Benefit Information
- ☐ For Claims Information
- ☐ For Service Determination Information
- ☐ At Request of Individual
- ☐ Other: _____

Persons Authorized to Disclose PHI: The person(s), class of persons, or entity authorized to make the disclosure:

- ☐ My Health care provider(s)
- ☐ My Insurance carrier
- ☐ Other: _____

Persons Authorized to Receive the Disclosure of PHI: The person(s), class of persons, or entity authorized to receive the PHI:

Alight Solutions: Advocacy 4 Overlook Point
Lincolnshire, IL 60069
(Fax) 847-554-1598

This authorization will expire:

- ☐ Remain in place until_____. (*Date*)
- ☐ On occurrence of the following event (which must relate to the Individual or to the purpose of the use and/or disclosure being authorized):_____

Note the following:

- I understand that I may **revoke** this authorization at any time by giving written notice of my revocation to the HIPAA Member Rights Unit at the address provided below. I understand that any revocation of this authorization will *not* affect any action Alight took in reliance on this authorization before Alight received my written notice of revocation. I also understand that any revocation of this authorization will **not** result in my disenrollment from or denial of my eligibility for benefits.
- Your decision to sign this Authorization is voluntary and said decision will not impact treatment, payment, enrollment or eligibility for benefits under your coverage plan.
- Parent or Guardian signature required for patients under the age of 18.

I have read and understand the contents of this document and am hereby providing my agreement to the terms of this Authorization.

Signature: _____ Date: _____