AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

MEMBER'S NAME: _____
ADDRESS: _____
(Street, City, State, and Zip Code)
TELEPHONE NO: (area code) _____
EMPLOYEE OR SUBSCRIBER NAME: _____
SUBSCRIBER ID: _____

My protected health information is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse and relates to: (i) my past, present, or future physical or mental health or condition; (ii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of health care to me.

I authorize Egyptian Trust Coordinated Health/Care to use and disclose my protected health information as described below.

The protected health information that may be used and disclosed is as follows:

_____
_____
_____

(Describe in as much detail as possible the protected health information that you wish to be used or disclosed. For example, all information related to my plan)

The following Individual(s), Provider(s), or Organization(s) is authorized to receive my protected health information:

_____
_____
_____

(Please list the specific names if possible, i.e. not just spouse, children, parents, etc)

I understand that I may refuse to sign this authorization. I further understand that my group health plan will not condition enrollment in the plan or eligibility for benefits on my signing this authorization.

I understand that I may revoke this authorization at any time by sending a written notification and this revocation will be effective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective for information that already was used or disclosed, relying on this authorization.

This authorization expires: _____, (list expiration date or event)
This authorization will expire at the termination of coverage, if no expiration date or event is listed

_____ _____
Signature of Member or Personal Representative * Date

_____
Print Name of Member or Personal Representative *

_____
Description of Personal Representative's Authority

* This form should be signed by the member. If the member is unable to sign a Personal Representative may sign on their behalf; if the representative has the appropriate authority.

Fax: 1-877-498-3690 **Mail: Coordinated Health/Care 7450 Huntington Park Drive, Suite 100 Columbus, OH 43235**