Authorization for release of personal and health information

Priority Health

A. MEMBER WHOSE INFORMATION IS TO BE RELEASED

Member name	Member date of birth	Contract number (on your membership card)

Street address	City	State	ZIP

Phone number that we may use to contact you	Alternate number that we may use to contact you *(optional)*
☐ Landline (home phone) ☐ Cell phone	☐ Landline (home phone) ☐ Cell phone

I request and authorize Priority Health* to release my personal and health information. This may include claims and billing information. It may also include medical records that Priority Health has received from medical practitioners, including records regarding general medical care, alcohol and drug abuse treatment, psychological or psychiatric treatment, social services counseling, human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) or AIDS-related complex (ARC), communicable diseases or infections, venereal diseases, tuberculosis, hepatitis and demographic information.
(*"Priority Health" includes Priority Health/Priority Health Managed Benefits, Inc./Priority Health Insurance Company/Priority Health Choice, Inc.)

B. TYPE OF INFORMATION PRIORITY HEALTH MAY RELEASE (CHECK ONE BOX)

☐ All of my information (including personal, health, demographic, claims, billing and medical records) **OR**
☐ Only my claims and billing information **OR**
☐ Other, such as information regarding a specific date of service or issue (explain) _____

C. WHO MAY RECEIVE YOUR INFORMATION?

Individual/entity name

Street address	City	State	ZIP

Primary phone number	Alternate number *(optional)*
☐ Landline (home phone) ☐ Cell phone	☐ Landline (home phone) ☐ Cell phone

D. WHAT IS THE PURPOSE OF THIS AUTHORIZATION? (CHECK ONE BOX)

☐ At my request ☐ Other (explain) _____

E. WHEN WILL THIS AUTHORIZATION EXPIRE? (CHECK ONE BOX)

Note: If I fail to list an expiration date or event below, this authorization will expire one year from the date signed.

☐ Upon my coverage termination
☐ On the following date _____ / _____ / _____ (MM/DD/YYYY)
☐ Upon my death
☐ Upon my written revocation

I understand that I may refuse to sign this Authorization. I may revoke this Authorization at any time by notifying Priority Health in writing at the address listed below. The revocation will not be effective for information that Priority Health discloses between the time that this Authorization is signed and when the revocation is received. If Priority Health requested this Authorization, I understand that I have the right to receive a copy of this Authorization after I sign it. I understand that Priority Health will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization. I understand that the persons to whom information is disclosed under this Authorization may possibly redisclose the information to others without my knowledge or consent, and therefore, the privacy of my personal and health information may no longer be protected by law.

F. SIGNATURE REQUIRED

If signed by a person other than the member, please check the relationship and provide proof of authority to do so:

☐ Parent of a minor child*
☐ Power of attorney
☐ Legal guardian
☐ Personal representative of deceased member

*This form will expire upon minor's 18th birthday and the below still applies: minor signs their own consent to release their own information related to the following conditions: Mental health (ages 14+ only), Substance abuse (any age), Sexual health (any age)

Signature	Printed name	Date

G. FINALIZE AND SEND

- Form must be fully completed

- Submit form via one of the following:
  - Scan and email to *HIPAA@priorityhealth.com*
  - Fax to: 616.942.0616
  - Mail to: Priority Health, MS 1065, 1231 East Beltline, N.E., Grand Rapids, MI, 49525-4501

This form satisfies all required elements of a valid authorization under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).