



RELEASE OF INFORMATION FORM

Purpose: This form is used to confirm a Member's authorization to release information, which may include the use or disclosure of their protected health information for a particular purpose other than normal payment and operations. Use of their information under this authorization is strictly limited to that purpose described below.

Section A: Type of Information

- Personal Health Information
- Psychotherapy Notes*

* If this authorization is for the release of psychotherapy notes, it may not be used in conjunction with an authorization for any other type of information.

Section B: Member Information

I authorize the use and disclosure of my personal health information as described below. I understand this authorization is voluntary and confirms my consent to the described activity. I understand that my information will be released to the person or organization listed below. I understand that if this person or organization is not a health plan, provider or other entity subject to federal privacy laws, they may further disclose my information and it may no longer be protected by federal privacy laws.

Member Name:

Address:

Telephone Number: ()

Member ID Number:

e-mail Address:

Section C: Authorized Use and / or Disclosure

Information to be disclosed: Provide a specific and meaningful description of the personal health information you are authorizing to be used or disclosed. Information may be limited by a related date range, service or diagnosis.

Purpose for the use / disclosure: Provide a description of the purpose or function for which the information may be used.

Entity Authorized to Release Information:

Entity Authorized to Receive Information:

Entity:

Address:

Section D: Expiration and Revocation

This authorization will automatically expire on ____/____/20__.

(Not to exceed 12 months from the date of signature below.)

I understand that I have the right to revoke this authorization at any time by giving written notice that I chose to revoke my consent to the contact listed below. I understand that revocation of this authorization will not impact any action that you have taken based upon this authorization prior to your receiving my request to revoke it.

Contact Person:

email Address:

Address: AmeriCorps, P.O. Box 3430, Carmel, IN 46082-3430

Section E: Signature / Authorization

I, _____, have had full opportunity to read and consider the content of this authorization form. I confirm that this authorization is consistent with my request of the health plan. I understand that, by signing this form, I am confirming my authorization that the health plan may use and / or disclose my personal health information to the person or entity named on this form for the purpose described above.

Signature:

Date:

If this form is signed by a person other than the Member, please complete the following:

Personal Representative's Name:

Relationship to the Individual:

**RETURN THE SIGNED AUTHORIZATION FORM TO THE CONTACT PERSON LISTED IN SECTION D.
YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION FORM AFTER YOU SIGN IT**