



You may give written Authorization to disclose your protected health information (PHI) to anyone that you designate and for any purpose. If you wish to authorize a person to receive your PHI, please complete the information below. Unless this Authorization form is filled out, PHI will **NOT** be disclosed to anyone other than the patient. An Authorization **MUST** be filled out for each person you wish to receive your PHI. In addition, an Authorization **MUST** be completed by each of your adult dependents. Please note that in most cases an Authorization is **NOT** required for a parent or legal guardian to receive PHI on a minor child.

Patient's Name	
Patient's Date of Birth	
Patient's Daytime Telephone Number	
Insured's Name (if different than patient)	
Insured's Member ID	
Last 4 digits of SSN	
Insured's Date of Birth	
Patient's Address	
Insured's Employer	

AT MY REQUEST, I AUTHORIZE MY PROTECTED HEALTH INFORMATION TO BE RELEASED AS FOLLOWS (enter name of person or entity who will receive your PHI)

Name	Relationship to Patient
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Please provide the following information to the person you have authorized to receive your PHI so that we may verify the person's identity and authority to receive your PHI: (1) member ID# and last 4 digits of the insured's social security number and (2) patient's date of birth.

I AUTHORIZE DISCLOSURE OF THE FOLLOWING PHI TO THE PERSON/ENTITY LISTED ABOVE (If you are **not** checking "All Information requested", then please CHECK ALL THAT APPLY)

ALL information requested

 Benefit Information

 All Claims Information
 Premium Payment Information

 Explanation of Benefit (EOB) Information

 Enrollment Information
 All Services from a **specific** health care provider (list name of provider) _____
 Other (list specific PHI) _____



THIS AUTHORIZATION WILL EXPIRE ONE YEAR AFTER THE TERMINATION OF ENROLLMENT IN THE HEALTH PLAN OR ONE YEAR AFTER THE TERMINATION OF INTEGRA BMS ADMINISTERING THE HEALTH PLAN, WHICH EVER OCCURS FIRST.

You have the right to set your own expiration date other than that above. If you do not want this authorization to expire as stated above, please indicate the specific expiration date of this authorization: _____

I understand that I may revoke this Authorization at any time by giving the Plan Sponsor (employer) and/or the Plan Supervisor (Integra BMS) written notice mailed to the address below. However, if I revoke this Authorization, I understand that the revocation will not affect any action taken which was based upon the reliance of this Authorization before receipt of my written notice of revocation was received by the Plan Sponsor and/or the Plan Supervisor.

I also understand that the Plan Sponsor will not condition the provision of health plan benefits on this Authorization.

I further understand that if the persons I authorize to receive my PHI are not health plans, covered health care providers or health care clearinghouses subject to the Health Insurance Portability and Accountability Act (HIPAA) or other federal information privacy laws, they may further disclose the PHI and it may no longer be protected by HIPAA or federal health information privacy laws.

Signature

Date

Signature of personal representative (if applicable)

Describe your authority to act for the patient (e.g. power of attorney, court order, etc)

(Please attach the legal document naming you as the personal representative)

A copy of this Authorization will be kept on file at Integra BMS (the Plan Supervisor)

RETURN THIS COMPLETED AUTHORIZATION TO:

Integra BMS

PO Box 1178

Matthews, NC 28106

Attn: HIPAA Privacy Coordinator

Fax: (704) 845-5629