AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

**Denotes required information*

Member Name: *_____ Date of Birth: * _____

EHP Policy Number: * _____ Telephone: _____

As required by the Health Insurance Portability and Accountability Act (HIPAA), The Cleveland Clinic/Akron General Employee Health Plan (EHP) as administered by UMR, in addition to EHP Medical and Pharmacy Management Departments, may not use or disclose your health information except as provided in the CCHS and Akron General EHP Privacy Notice of Insurance Information Practices, which is located on the EHP Website under "About Us." Your signature on this form indicates that you are giving permission for certain use or disclosure of your health information.

I authorize the use or disclosure of my individually identifiable health information as indicated below by EHP, UMR, EHP Medical and Pharmacy Management Departments to the following individual or entity (must include name, address, and relationship): *

PLEASE PRINT

Last Name: * _____ First Name: * _____

Address:* _____

CIRCLE RELATIONSHIP: * Spouse Domestic Partner Child Parent Sibling Power of Attorney Guardian Friend Other

The specific health information to be used or disclosed (please check all that apply): *

- ☐ Claim Payment Information
- ☐ Application/Enrollment Information
- ☐ Medical Records
- ☐ Healthy Choice Information (health status, medical condition, participation, etc.)
- ☐ Other_____

Reason or purpose of providing the health information to the individual/entity named above: *

_____

I understand this authorization will only be in effect from the corporate received date through coverage termination.

I also understand that I may revoke this authorization at any time by providing UMR with written notice of revocation. If I do revoke this authorization, it will not have any effect on any information released before UMR receipt of the revocation, including any action taken by the individual/entity that received the health information. Health information used or disclosed as instructed by this authorization may be further disclosed by the individual/entity receiving the health information and, therefore, no longer protected by the HIPAA privacy law.

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain insurance or eligibility for benefits will not depend in any way on whether I sign this authorization.

_____ _____

Signature of the individual who is the subject of the health information to be used/disclosed* Date*

_____

If signed by Legal Representative, relationship to member (attach proof/court documentation): *

Submit this request to UMR, Attn: Privacy Office, 11 Scott Street, Wausau, WI, WI 54403. You may also fax this form to: 888.742.4179, Attn: Privacy Office