HIPAA Release of Information
AUTHORIZATION FORM

I, ____________________________________hereby authorize GlobeHealer and its affiliates, its employees and agents, to release my personal health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) **except** the following information about me:_________________________________ **[DESCRIBE INFORMATION NOT TO BE DISCLOSED, IF ANY].**

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

This authorization is valid from the date of my/my representative's signature below and shall expire the earlier of __________________________ **[INSERT DATE UPON WHICH THIS AUTHORIZATION EXPIRES.**

I understand that I have a right to revoke this authorization by providing written notice to GlobeHealer. However, this authorization may not be revoked if GlobeHealer, it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for enrollment or payment for or coverage of services.

Name of Member: ____

Signature of Member: _______________________________________

Date:______________________________

If applicable, Legal Representatives sign below:
By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

Name of Legal Representative: ____________________________________

Signature of Legal Representative: _________________________________

Date: _________________________________

Name of Witness: ____

Signature of Witness: _____________________________________