

**GROUP BENEFIT ADMINISTRATORS
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION**

I, _____, hereby authorize GROUP BENEFIT ADMINISTRATORS and its administrative manager
(print patient name)
to use or disclose my protected health information as described in this authorization. (Attach additional pages if necessary)

(1) *Specify person/organization (or class of persons) authorized to receive and use the information:*

NAME: _____
ADDRESS: _____
CITY, STATE, ZIP: _____
PHONE #: _____ FAX #: _____
SOCIAL SECURITY NUMBER **OF OUR INSURED**: _____

(2) *Information to be released:*

- ALL INFORMATION, NO RESTRICTIONS.
- Payment of specific claim: _____
- Duplicate Explanation of Benefit form (EOB): _____
- Payment of claims for specified period: _____
- Other (specify): _____

(3) *Purpose of the request:* (Please state the purpose of the request. If you do not wish to state a purpose, please state, **“AT THE REQUEST OF THE INDIVIDUAL.”**)

(4) *Right to revoke:* I understand that I have the right to revoke this authorization at any time by notifying the Plan in writing at Group Benefit Administrators, Attention: Privacy Officer, P.O. Box 30749, Salt Lake City, UT 84130, Telephone 801-972-1177 or toll free at 1-800-657-5377 or Fax at 801-972-3364. I understand that the revocation is only effective after it is received and logged by the Plan. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

(5) I understand that after this information is disclosed, federal law might not protect it and the recipient might re-disclose it.

(6) I acknowledge that I have received a copy of this authorization, and understand that payment of benefits, or enrollment in or eligibility under the Plan, are not conditioned upon my signing this authorization.

(7) I understand that this authorization will expire when I am no longer covered by the Plan.

SIGNATURE OF PATIENT: _____

OR SIGNATURE OF PERSONAL REPRESENTATIVE:

(**see below for details): _____

THIS FORM MUST BE NOTARIZED!

SUBSCRIBED AND SWORN to before me this _____ day of _____, _____.

(NOTARY PUBLIC)

****Personal Representative Section:**

If a Personal Representative or the patient executes this form, that Representative warrants that he or she has authority to sign this form on the basis of:

- Power of Attorney (ATTACH COPY)
- Court Order (ATTACH COPY)
- Custodial Parent of unemancipated minor child under 18 years of age.
(If you were awarded custody pursuant to a Decree of Divorce, ATTACH COPY)