Delaware Valley HEALTH INSURANCE TRUST

Authorization for Release of Personal Health Information

Important Information Regarding Your Rights

- **You may refuse to sign this form**
- **Signing this form may not be considered a condition of enrollment, or a requirement to receive healthcare benefits**
- **This authorization may be revoked anytime prior to its expiration date by notifying the company or companies named below in writing. The revocation will not have any effect on actions taken or information provided prior to the receipt of the revocation.**
- **The company or companies named below may re-disclose the information provided pursuant to this authorization. However, you have the right to seek assurances from the company or companies that the information will not be re-disclosed.**

Information Regarding the Use and Disclosure of Your Personal Health Information

I authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary and that I may revoke it at any time by submitting a revocation in writing to the persons/organizations providing the information.

Patient Name: _____ ID Number: _____

Persons/organizations authorized to provide the information:

_____

Persons/organizations authorized to receive the information:

_____

Specific description of information to be used or disclosed (must include dates)

Specific Purpose of the disclosure:

- ❑ So my employer's benefits personnel/benefits trust organization may assist in the proper adjudication of my pending claims (list specific claims/illness: _____)
- ❑ So my employer's benefits personnel/benefits trust organization may assist in the appeal of my claims denial/difficulty (list specific claims/illness: _____)
- ❑ So my insurance company may discuss my health information with my spouse/significant other, as named above (list specific information to be disclosed: _____)
- ❑ Other (Must specify): _____

The organization requesting the information will not receive financial or in-kind compensation in exchange for using and disclosing the health information described above. The authorization will expire on:

_____

Signature of patient or patient's representative: _____

Printed name of patient or patient's representative:

_____

Signature of Trust Representative:

_____

Relationship to the patient, including authority for status as representative: _____