INDIVIDUAL AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

This authorization is not valid unless it is filled out completely. This form cannot be used as a joint authorization with another member; therefore, each member must submit an individual form. Please type or print the information.

1. MEMBER (Name and information of person whose protected health information is being disclosed):

NAME _____ **D.O.B.** _____

GROUP # _____ **MEMBER ID#** _____ **SOCIAL SECURITY #** _____

ADDRESS _____

PHONE # _____

2. AUTHORIZATION and PURPOSE

I request and authorize Core Management Resources to disclose my protected health information to the following Persons/Organizations:

NAME _____ **RELATIONSHIP** _____

PHONE # _____ **PURPOSE** _____

ADDRESS _____

3. PROTECTED HEALTH INFORMATION

I authorize access of the following information *(check one or more)***:**

☐ Any information requested

☐ All claims information

☐ Access to information listed on *CoreLink II* (online claim website)

☐ Other (please specify) _____

☐ Benefit information

☐ Explanation of Benefits information

☐ Enrollment information

4. EXPIRATION

This authorization will expire on *(must choose one)***:**

☐ One year from the date form is signed ☐ Other (insert date or event) _____

5. EXPLANATION OF RIGHTS. I understand that:

- I have the right to refuse to sign this authorization; refusal to sign will not adversely affect my ability to receive health care services or reimbursement for services.
- I have the right to inspect or receive a copy of the protected health information that will be used or disclosed by Core.
- The information used or disclosed pursuant to the authorization may be subject to re-disclosure and may no longer be protected by the regulations that require payers to protect individual health information.
- I can revoke this authorization at any time by submitting a written request to the address below.

Return the completed form by:

FAX (478)-745-1843

EMAIL help@corehealthbenefits.com

MAIL Privacy Officer
Core Management Resources Group, INC.
PO Box 1755
Macon, Georgia 31202

_____
Date

_____
Signature of Member

_____
Printed Name of Member

_____
Authority of Personal Representative
(If signing for the Member)