



Authorization for Use and Disclosure of Private Health Information

Description of PHI to be released to Health Champion:

I hereby authorize my health plan(s), my healthcare providers and their applicable business associates to disclose the following Private Health Information (“PHI”) pertaining to me: medical information including pertinent lab results, enrollment, claims, payment and managed care information to Health Champion, Inc. for the purpose of assisting me in my quest to identify and obtain appropriate health care services, and/or approval or payment for health care services.

Unless otherwise indicated, my authorization includes the release of the following:

(Please strike through those you wish to exclude, if any.)

- Diagnosis and/or treatment for alcoholism and/or drug abuse or dependency
- Diagnosis and/or treatment regarding mental health issues
- HIV antibody test results and/or diagnosis and treatment
- Genetic test results and/or related treatment

Identification of person authorizing release: (Please complete all items.)

Name of Member/Participant:

Social Security #: _____

Date of Birth: _____ Relationship to Subscriber: _____

Address: (include Street, City, State, Zip)

Subscriber Name: _____

Subscriber's Social Security #: _____

Subscriber's Sponsor Name: (eg: Employer, Health & Welfare Fund) _____



Health Champion LLC Authorization for Use and Disclosure of Private Health Information (con't)

Health Insurance Carrier 1: _____

Health Insurance Carrier 2: _____

Coverage Type-Carrier 1: HMO POS PPO Indemnity Medicare ID#: _____

Coverage Type-Carrier 2: HMO POS PPO Indemnity Medicare ID#: _____

**Unless otherwise revoked, this authorization will commence on the date indicated below and will expire on the following date, event or circumstance: _____
_____. If I fail to specify, this authorization will expire in twelve months.**

- I understand that information used or disclosed based on this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.
- I understand that I may revoke this authorization at any time by giving written notice of my revocation to Health Champion’s Privacy Officer at the above address. I understand that revocation of this authorization will not affect any action Health Champion or other parties took in reliance on this authorization before it received my written notice of revocation.
- I understand that Health Champion provides administrative and informational services only and does not provide health insurance or medical services nor does it recommend treatment. Consequently, independent health care practitioners, who are not employees or agents of Health Champion, will provide all my medical services.

Signature: _____ **Date:** _____

(Personal Representative) (Include a description of such authority to act for the patient.)

You are not required to authorize Health Champion to have access to your “PHI” and the provision of treatment, payment, enrollment or eligibility for benefits does not depend on whether you sign this authorization. You should keep a signed copy of this authorization for your records, however, a copy of this signed authorization will be provided upon your request.