Authorization to Disclose Health Information

Member Information: (Individual whose information will be released)

Name: _____ Date of Birth: _____
(First, Middle, Last) (Month/Day/Year)

Address: _____
City State Zip Code

Telephone Number: _____ Email Address: _____
(Including area code)

Employer Name: _____ Group Plan #: _____

Employee Name: _____ Social Security Number: _____

I prefer that the Plan communicate with me by: ☐ calling me at the number above, ☐ sending mail to the address above, or ☐ sending me an electronic message at the e-mail address above.

I authorize the use or disclosure of personal and health information by Group Resources as described below:

☐ Any and all health information in the possession of GRI

☐ Claim information regarding treatment for the following condition or injury _____

_____ on or about _____

☐ Health information covering the period of time _____ to _____

☐ Other (Please specify and include dates) _____

_____

This information may be disclosed to, and used by, the following individuals or organizations:

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

This information is being disclosed for the following purpose(s):

_____

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and send my written revocation to GRI, P.O. Box 100043, Duluth, GA 30096-9343.

I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to GRI when the law provides it with the right to contest a claim under my group plan. Unless otherwise revoked, this authorization will expire within thirty (30) months of the signature date.

I understand that I do not have to sign this authorization and that GRI may not condition treatment or payment on whether I sign this authorization.

I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.

Print Name: _____ Relationship: _____

Signature: _____ Date: _____

Note that no authorization to disclose health information will be processed unless you or your authorized representatives have signed this form.

If you are an authorized representative (other than a parent of a minor child), you will need to provide documentation or an explanation to your authority to act for the member (e.g., Power of Attorney).

Please sign and fax this form to:

AIRMI, Inc.
c/o Debby Smith
(404) 658-1114