HealthComp®
Third Party Administrators

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

MEMBER'S NAME: _____

MEMBER I.D. NO.: _____

I authorize the use and disclosure of my protected health information to HealthComp Administrators so they can determine coverage, perform medical/utilization review, or coordinate benefits with my other health plan or insurer.

My protected health information is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse and that relates to: (i) my past, present, or future physical or mental health or condition; (ii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of health care to me.

I understand that if my protected health information is to be received by individuals or organizations that are not health care providers, health care clearinghouses, or health plans subject to federal privacy regulations, my protected health information described above may be re-disclosed and no longer protected by federal privacy regulations. I understand that I may revoke this authorization at any time by sending a written notification to the requesting party, and this revocation will be effective for future uses and disclosures of protected health information.

This authorization expires one year from the date of my signature below.

SIGNATURE: _____

DATE: _____

If this authorization was signed by a personal representative on behalf of the individual, complete the following:

PERSONAL REPRESENTATIVE'S NAME:
_____

DESCRIPTION OF AUTHORITY:
_____