PriorityHealth

Authorization for release of personal and health information

A. Member whose information is to be released

Member name:	Address:
Contract number on ID card:	City:
Date of birth:	State:
Phone number:	Zip Code:

I request and authorize Priority Health* to release my personal and health information. This may include claims and billing information. It may also include medical records that Priority Health has received from medical practitioners, including records regarding general medical care, alcohol and drug abuse treatment, psychological or psychiatric treatment, social services counseling, human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) or AIDS-related complex (ARC), communicable diseases or infections, venereal diseases, tuberculosis, hepatitis and demographic information. (* "Priority Health" includes Priority Health/Priority Health Managed Benefits, Inc./Priority Health Insurance Company/Priority Health Government Programs, Inc.)

B. Type of information Priority Health may release (Check ONE box)

☐ All of my information (including personal, health, demographic, claims, billing and medical records); **OR**

☐ Only my claims and billing information; **OR**

☐ Other (explain): _____
(such as information regarding a specific date of service or issue)

C. Who may receive your information?

Individual / Entity name: Legal Copy Services, Inc. PO Box 2845 Grand Rapids, MI 49501

Address: PO Box 2845

City / State / Zip Code: Grand Rapids, MI 49501

Phone number: 877-949-1313

D. What is the purpose of this Authorization? (Check ONE box)

☐ At my request ☑ Other (explain): 3rd Party Discovery for Civil Litigation

E. When will this Authorization expire? (Check ONE box)

☐ No expiration ☐ Upon my death ☐ Upon my coverage termination ☐ Upon my written revocation

☐ On the following date: ____/____/____ (MM / DD / YYYY) ☑ On the following event: One year from date of signature

NOTE: If I fail to list an expiration date or event above, this Authorization will expire one year from the date signed.

I understand that I may refuse to sign this Authorization. I may revoke this Authorization at any time by notifying Priority Health in writing at the address listed below. The revocation will not be effective for information that Priority Health discloses between the time that this Authorization is signed and when the revocation is received. If Priority Health requested this Authorization, I understand that I have the right to receive a copy of this Authorization after I sign it. I understand that Priority Health will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I understand that the persons to whom information is disclosed under this Authorization may possibly redisclose the information to others without my knowledge or consent, and therefore, the privacy of my personal and health information may no longer be protected by law.

F. Signature required below

Signature: _____ **Date:** ____/____/____ (MM / DD / YYYY)

Printed name: _____

If signed by a person other than the member, please check the relationship **and** provide proof of authority to do so:

☐ Parent of minor child ☐ Power of attorney ☐ Legal guardian ☐ Personal representative of deceased member

Form must be fully completed

Scan and email to: HIPAA@priorityhealth.com or **fax to:** 616 942-0616 or

Mail to: Priority Health, MS 2005, 1231 East Beltline, N.E., Grand Rapids, MI, 49525-4501

This form satisfies all required elements of a valid authorization under the Health Insurance Portability and Accountability Act of 1996 (HIPAA)