

# Authorization to Release Health Information

**Form is not valid unless fully completed. Please return with a photocopy of your government-issued photo ID for verification of signature.**

**Policyholder Information**

Last Name \_\_\_\_\_ First \_\_\_\_\_ Subscriber ID# (on ID card) \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Ph# (\_\_\_\_\_) \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date \_\_\_\_\_

**I understand the following information:**

1. Once SelectHealth releases information according to this Authorization, SelectHealth cannot guarantee that this information will not be rereleased to a third party or that this information will be protected by federal and state law governing the use and disclosure of identifiable health information;
2. This Authorization will remain in effect until it expires or until I provide a written notice of revocation to SelectHealth;
3. I may refuse to sign or may revoke this Authorization at any time for any reason, except to the extent that SelectHealth has already made disclosures in reliance on this Authorization; and
4. While SelectHealth does not condition the commencement, continuation, or quality of health insurance, care management, and other services it provides to me on my signing and not revoking this Authorization, my refusing to sign or revocation of this Authorization may limit SelectHealth's ability to provide such services to me.

In understanding the above, I agree to allow SelectHealth to release my information as described in this Authorization. If I have questions about such disclosures, I can contact SelectHealth at 801-442-5038 (Salt Lake area) or 800-538-5038.

**SelectHealth may release information about the following people on the policy:**

1. Member Last Name	First	Date of Birth	Month	Day	Year
2. Member Last Name	First	Date of Birth	Month	Day	Year
3. Member Last Name	First	Date of Birth	Month	Day	Year
4. Member Last Name	First	Date of Birth	Month	Day	Year
5. Member Last Name	First	Date of Birth	Month	Day	Year

Expiration Date of this Authorization \_\_\_\_\_ or Expiration Event \_\_\_\_\_

*If you do not give an expiration date or an expiration event, this Authorization will remain in effect until the later of: 1) three years from the date that the member's eligibility has terminated; or 2) one year from the date of signature.*

**Information may be released to the following person/organization (only one person/organization per form):**

Name of person or organization	Date of Birth	Month	Day	Year
Address: Street, City, State, ZIP	Ph#	( )		

**Purpose of disclosure**

- For assistance in claims' payment or processing     
 Maintain policy contact information     
 At the request of the individual  
 For assistance with prenotification information     
 Enrollment information inquiry     
 Other \_\_\_\_\_

**Information to be released** Check the box(es) below to indicate which information you would like released.

- Enrollment Information - Includes information about whether an individual is currently enrolled, including effective dates and premiums paid  
 Policy Contact Information - Includes home telephone and the primary location for mailing materials to members including street address, city, state, ZIP code  
 Appeal Information - Includes information about the appeal, status, decision letters, and a copy of the information that is relevant to the appeal decision  
 Prenotification Information - Includes number of days or visits authorized, the provider of service, type of service, description of service, status of prenotification, and concurrent review information, including all materials used in decisions made during the concurrent review process  
 Care Management - Includes all records involving treatments, services, tests, and diagnoses  
 Claims' Payment Information - Includes the following:
- |                           |                  |                      |   |
|---------------------------|------------------|----------------------|---|
| • Benefit information     | • Billing codes  | • Claims' status     | • Amount paid toward the yearly deductible  |
| • Date of service         | • Billed amount  | • Copays             | • Amount paid toward the yearly out-of-pocket maximum   |
| • Service provider        | • Allowed amount | • Deductible         | • Diagnosis information if a claim was denied because of the diagnosis code or if the diagnosis determined the type of benefit used for payment |
| • Description of services | • Paid amount    | • Coinsurance amount |   |

**Other Description**

Signature of member or legal representative	Date	Month	Day	Year
Print name	If signed by legal representative, description of authority			

**I have included a photocopy of my government-issued photo ID for verification of signature** (Authorization is not valid until ID has been received.)

## SELECTHEALTH USE ONLY: ATTENTION MEMBER SERVICES

Password \_\_\_\_\_

Security Question \_\_\_\_\_

Security Question Answer \_\_\_\_\_