

## Authorization to Release Health Information for Care Management

### POLICY HOLDER INFORMATION

Patient Name \_\_\_\_\_ Subscriber ID# (on ID card) \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Ph# (\_\_\_\_\_) \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date \_\_\_\_\_

### AUTHORIZATION

By signing below, I authorize \_\_\_\_\_ to discuss with SelectHealth my health information and records for purposes of care management. I authorize to be released all health information, including all records involving treatments, services, tests, and diagnoses.

#### I Understand the Following:

By signing below, I also indicate that I understand the following:

1. I may refuse to sign this Authorization;
2. I may withdraw this Authorization at any time for any reason by providing written notice of withdrawal to SelectHealth except to the extent that disclosures have already been made relative to this Authorization;
3. SelectHealth may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization;
4. Once SelectHealth releases information according to this Authorization, SelectHealth cannot guarantee that this information will not be re-released to a third party or that it will be protected by federal and state law governing the use and disclosure of identifiable health information;
5. Unless revoked, this Authorization will remain in effect for two years from the date of signature.

### SIGNATURE AND DATE

Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_

\_\_\_\_\_  
Description of authority if signed by legal representative (e.g., parent/guardian of minor child).