



## Authorization for Use and Disclosure of Protected Health Information

**Please Print:**

Member (Patient) Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Member (Patient) Address \_\_\_\_\_

Member I.D. #: \_\_\_\_\_

I authorize Physicians Health Plan (PHP) to use and disclose my (or patient's) protected health information to the following person(s):  
(specify-please print) \_\_\_\_\_

*Please check the appropriate box or boxes below. You may write in any additions or limitations. Authorization is not valid if this section is not filled out.*

**Copies or contents of the following records may be used/disclosed as requested:**

☐ All healthcare information including any mental health, drug/alcohol abuse, or communicable disease treatment records that may be maintained by PHP.

☐ Limit disclosure to all healthcare information, **EXCLUDING** any mental health, drug/alcohol abuse, or communicable disease treatment records that may be maintained by PHP.

☐ Limit disclosure to Benefit / Coverage information.

☐ Other (specify) \_\_\_\_\_

☐ Limit above disclosure to healthcare services provided between the following dates: \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

**Purpose of the disclosure:** *Check the appropriate box or boxes, or fill in blanks that apply. Authorization is not valid if this section is not filled out.*

☐ Personal use or assistance ☐ Assistance with a grievance/appeal ☐ Legal action\* (please specify) ☐ Other (please specify)

\*Please describe legal action or other purpose \_\_\_\_\_

This authorization expires on \_\_\_\_\_ (If no date is specified, this authorization expires 180 days after the signature date.)

### Important Information About Your Rights

I understand that:

- I am not required to sign this authorization to receive my benefits except as allowed by law, such as when a disclosure is necessary for PHP to determine payment of a claim.
- I may request a copy of this signed authorization.
- I may revoke this authorization at any time prior to the expiration date by sending a written request to PHP; however, the revocation will not have any effect on any actions PHP took prior to receiving the revocation.
- The health information indicated above may no longer be protected by federal privacy regulations if disclosed to a party that is not a health plan or healthcare provider.
- If I choose to designate a representative to assist me, the representative will have access to my protected health information.

Signature of Member (Patient) \_\_\_\_\_ Date \_\_\_\_\_

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***If Patient is under the age of 18 years, or is otherwise unable to sign, a parent or other legally authorized individual should sign below.***

Signature for Patient \_\_\_\_\_ Date \_\_\_\_\_

Please print name clearly \_\_\_\_\_

Relationship to Patient: (please check appropriate box) ☐ Parent ☐ Spouse ☐ Legal Guardian\* ☐ Power of Attorney\*

☐ Other authorized representative\* (please specify relationship) \_\_\_\_\_

☐ Authorized as Next of Kin (use if patient is deceased or incapacitated, and no other authorized representative has been designated). Please specify relationship \_\_\_\_\_

\* Please supply applicable documentation of legal guardianship, power of attorney, or other legal authorization to represent Patient.

**PLEASE NOTE: EACH SECTION OF THIS FORM MUST BE COMPLETED IN ORDER TO BE VALID.**

If you need assistance to complete this form, please contact Customer Service (260) 432-6690, extension 11; (800) 982-6257, extension 11.

Please return completed forms to PHP Customer Service at 1700 Magnavox Way, Suite 201, Fort Wayne, IN 46804, or by email to [custsvc@phpni.com](mailto:custsvc@phpni.com).