MEMORIAL HERMANN Health Plan

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize Memorial Hermann Health Solutions, Inc., Memorial Hermann Health Insurance Company, Memorial Hermann Health Plan, Inc. or Memorial Hermann Commercial Health Plan, Inc. (collectively "MHHSI") to discuss and release my protected health information (PHI), as applicable, in writing, in person and/or by telephone, with the following individuals and for the following purpose:

Initial if applicable: _____Alcohol/Drug _____Genetics _____HIV/AIDS_____Mental Health
Check All that Apply:

❑ General Benefit Information	❑ Claims Information	❑ Demographic Changes	❑ Authorization/Referrals
❑ Billing/Premium	❑ Appointment Assistance	❑ Application/Eligibility	❑ Material Requests
❑ Complaint/Appeals	❑ ID Cards	❑ Other _____	

I understand this authorization is voluntary and I may refuse to sign this authorization. I further understand that my healthcare and the payment of my healthcare will not be affected if I do not sign this form. I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-healthcare provider, the released information may no longer be protected by federal and state privacy regulations.

I understand that I may revoke this authorization at any time by giving written notice to the address listed at the bottom of this form. I also understand that revocation of this authorization will not affect any action the above-named entity took in reliance on this authorization before the above-named entity received my written notice of revocation.

This document will expire upon revocation, or at the date or event specified here _____ .

Group Number	Member/Subscriber ID	Social Security Number
Member Name		Date of Birth MM/DD/YYYY
Street Address	City, State, ZIP	Telephone Number

The information will be released to:

Individual/Organization Name		Telephone Number
Street Address	City, State, ZIP	Fax Number
Individual/Organization Name		Telephone Number
Street Address	City, State, ZIP	Fax Number

Purpose of the use and/or disclosure: ❑ Continued Care ❑ Legal ❑ Insurance ❑ Personal Use ❑ Other _____
Record copy format: ❑ Paper ❑ CD ❑ _____ **Record copy delivery:** ❑ Pick-up ❑ Mail ❑ Fax to healthcare office

I understand that this document applies to all departments, healthcare providers and/or employees with MHHSI.

_____ _____
Signature of Member/Legal Representative (electronic signature not accepted) Date

_____ _____
Printed Name of Member/Legal Representative Relationship to Member

_____
Representative's Authority to Act for Member (attach supporting documentation)

Please return the completed form by mail or fax.

Mail: Attn: Customer Service
PO Box 19909, Houston, TX 77224
Fax: 832.786.4929
Email: mhhp_hipaa_designee@apex4health.com

Phone: General: 855.645.8448; TTY: 711

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION INSTRUCTIONS

You can give permission to Memorial Hermann Health Solutions, Inc., Memorial Hermann Health Insurance Company, Memorial Hermann Health Plan, Inc., or Memorial Hermann Commercial Health Plan, Inc. (collectively "MHHSI") to share your protected health information with an individual or an organization. To do so, you must complete and sign the Authorization for Release of Protected Health Information form.

Who can I authorize the release of my Protected Health Information to?

A few examples of a person/entity who would receive your Protected Health Information:

- A close friend
- A broker
- An attorney
- Specific member of his or her employer's benefits' staff
- An organization

How long does my permission last?

This authorization is valid until the earlier of the occurrence of:

1) The death of the individual, or
2) The individual reaching the age of majority, or
3) When you are no longer a MHHSI member, or
4) Permission is withdrawn (**must be in writing)**, or
5) Based on the event specified date you mentioned in the form

What can the authorized individual or organization do for me? They can:

- Get plan information, such as: General Benefit Information, Claims Information, Demographic Changes, Authorization/Referrals, Billing/Premium, Appointment Assistance, Application/Eligibility, Material Requests, Compliant/Appeals, ID Cards
- Any other information you outline in the form

Can I change my mind and revoke this authorization?

Yes, you can tell us to stop sharing your information at any time by sending a written statement of revocation to Memorial Hermann Health Solutions, Inc., Attn: Customer Service, PO Box 19909, Houston, Texas 77224. However, it's not possible to revoke information MHHSI has already shared.

Where do I send my completed form?

Memorial Hermann Health Solutions, Inc. Attn: Customer Service
PO Box 19909, Houston, TX 77224
Fax: 832.786.4929
Email: mhhp_hipaa_designee@apex4health.com

Remember to make a photocopy for your records.

Who do I call if I have questions?

Customer Service: 855.645.8448
TTY: 711