



**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:

<input type="checkbox"/> General Benefit Information	<input type="checkbox"/> Claims Information	<input type="checkbox"/> Demographic Changes	<input type="checkbox"/> Authorization/Referrals
<input type="checkbox"/> Billing/Premium	<input type="checkbox"/> Appointment Assistance	<input type="checkbox"/> Application/Eligibility	<input type="checkbox"/> Material Requests
<input type="checkbox"/> Complaint/Appeals	<input type="checkbox"/> ID Cards	<input type="checkbox"/> 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:**

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