



Adventist Risk Management Inc. ("ARM")
Health Benefits Services

Health Care Assistance Plan of Seventh-day
Adventist Organizations of the North
American Division working in the United
States ("HCAP")

PO Box 4288, Silver Spring, MD 20914-4759
Phone: (888) 276-4732 Fax: (301) 680-6844
Email: healthcare@adventistrisk.org

**AUTHORIZATION FOR
RELEASE AND USE OF
PROTECTED HEALTH
INFORMATION**

I hereby consent to the use or disclosure of my **individually identifiable health information/protected health information** described below ("Health Information"). I understand that this authorization is voluntary and that neither ARM nor the HCAP will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

I. Specific Protected Health Information to be Released. I authorize the disclosure of specific Health Information by ARM or the HCAP as noted below:

Unrestricted. *Unrestricted would indicate no restriction and could include both medical and financial information, i.e., benefit codes, diagnosis codes, procedure codes, etc; payment status of claim, to whom payment was sent; date and amount of payment, etc.*

Specific Date(s) of Service. _____ *Specific Date(s) of Service would limit information to be released to a specific treatment timeframe, i.e., dates of service from January through June of 2010.*

Specific Treatment(s). _____ *Specific Treatment(s) would limit information for a specific episode of care, i.e., pregnancy during 2009; or related to knee surgery in January 2010.*

Other. *(please specify)* _____

II. Persons/Organizations to Receive the Health Information. I authorize the disclosure and use of the Health Information described above to the following person(s) or organization(s) as noted below:

Spouse *(Name)* _____

Parent(s) *(Name)* _____

Employer Benefits Coordinator *(Name)* _____

Other *(please indicate relationship and name)* _____

III. Purpose of the Requested Use or Disclosure. I authorize the use or disclosure of the Health Information described above for the following purpose:

At my request.

Other *(please specify)* _____

IV. Expiration of this Authorization. This authorization expires on:

The following date: _____

The following event: _____

By signing below, I authorize Adventist Risk Management and/or the Health Care Assistance Plan to release my Health Information as indicated above. I understand I have the right to revoke this authorization at any time by submitting a written revocation to Adventist Risk Management. However, this authorization cannot be revoked to the extent that information has already been released in reliance on it. I understand that information disclosed pursuant to this authorization is subject to re-disclosure by the recipient or recipients and is no longer protected information.

Signature: _____ Date: _____

Printed Name: _____ Member ID Number: _____
See medical ID card (9 digit number)

Address: _____

For Your Information and Clarification:

Dependent Children: We are required to obtain this authorization from your adult children age 18 or over in order to release the children's information to parents or others: they may indicate "Unrestricted" and name one or both parents as well as Employer Benefits Coordinator. Once children are adults under state law (age 18 or older, this "legal age" varies from state to state), we may not release their health information to their parents unless they have authorized us to do so.

Information regarding dependents under 18 can only be released to either parent or legal guardian (unless there is a court order restriction), but requires parental consent for release other than as allowed by law. Under some state laws, certain health information may not be released to a parent without authorization by the dependent, even if under 18.

Spouses: In many instances, we are required to obtain this authorization from your spouse in order to release your spouse's health information to you.