Authorization for Disclosure of Personal Health Information

Your Name and Identification Information:

Name: _____ **D.O.B:** _____**Age:**_____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Telephone: _____ **Member ID #:** _____

Purpose:

Please read carefully and fill out all required information, to authorize disclosure of personal health information (PHI), which may include; health information, to persons/organizations outside of PHOENIX Benefits Management. Your privacy is protected by federal and state law, thus, we need your permission to disclose any information to outside parties. Please complete every section in this form.

Persons/Organizations to disclose member information:

Please include full name, and contact information (including: name, address, telephone number, etc.)

_____

_____

_____

What personal health information can we disclose?

Please be specific on what we are allowed to disclosed to persons/organizations, such as; prescription history, description of benefits, or "as requested by the organization or person." Once information is disclosed PHOENIX Benefits Management is not responsible how the information is used.

_____

_____

_____

Please describe the purpose of the disclosure:

_____

_____

_____

Expiration Date:

This form expires 90-days after the sign date. If you wish for the expiration date to be different please specify below. You may also ask for immediate expiration upon disclosure of information. Extensions on expiration date are allowed if specified.

_____

_____

Signature:

By signing this document I am authorizing PHOENIX Benefits Management to disclose information to the persons/organizations listed above. I understand the information disclosed will only pertain to the reasons stated above, and PHOENIX will only disclose the minimum necessary. I also understand I am under no obligation to sign this authorization. I also understand the services provided by PHOENIX will not be affected by signing this authorization. I fully understand my rights and risks in signing this form.

Signature: _____ Date:_____

Note: If you are acting on behalf of a member, you must provide legal documentation supporting legal authorization on patient's behalf, must be submitted prior to signing this form.

Disclosure:

Once the information is disclosed to the persons/organizations listed by you, the information is no longer protected by federal or state laws. Phoenix Benefits Management can no longer control the information, nor can we control what the persons/organizations do with it. We will not disclose certain types of information (such as behavioral health and HIV/AIDS information) unless specified by member or permitted or requested by law. You have the right to revoke the granted access at any time. However, if the revocation occurs after the information is provided to persons/organizations this will not apply since you initially provided permission. You may revoke by submitting a written notice (verbal notice will not be accounted for), by mail or email, no explanation required.

For further questions or to revoke the Authorization form contact:

Phoenix Benefits Management

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