AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Be sure to complete all responses.

TO: *(insert name of benefits administrator or provider who you are requesting to release information):*
____
____

Indicate GE Health Plan: HCP: ____GEMB: ____ GE Health Choice: ____ GE Health Benefits: ____
Other (insert name): ___________________________

Name of individual authorizing use or disclosure: ____
Subscriber ID/SSN#: _____________ ____
Address: _____________________ ____
Telephone #: (____)______-_________Fax # (____)______-________ Cell Phone #(____)______-__________

I authorize the use or disclosure of the above-named individual's information as described below. *Check all that apply:*

- ❑ Any and all records including mental health, HIV/AIDS, genetic testing and/or substance abuse records. (*Cross out any item you do not authorize to be released)*
- ❑ Records regarding treatment for the following condition or injury ________________________________ ________________________________ on or about ____
- ❑ Records covering the period of time ____________________ to ________________________________
- ❑ Other (Please specify and include dates)____ ____

This information may be disclosed to, and used by, the following individuals or organizations:
Name: ____
Address: ____
Name: ____
Address: ____

Please indicate the purpose(s) for this release of information. *Check all that apply:*

☐ Enrollment information ☐ Benefit or Coverage information ☐ All claims information

☐ All services from a specific health care provider (List provider's name): ____________________________

☐ For the following purposes:
____

- This authorization is voluntary.
- I may revoke this authorization at any time by notifying in writing the company/individual listed above from providing the information identified in this authorization, but if I do revoke this authorization, it won't have any affect on any actions taken before my revocation was received.
- I would like this authorization to expire on (enter date): _____/_____/_____
  (If no expiration date is provided, this authorization will expire twelve (12) months from the date of receipt)
- Payment, enrollment or eligibility for benefits for my health care will not be affected if I do not sign this form.
- Information disclosed as a result of this authorization may no longer be protected by federal privacy laws and may be disclosed by the company or individual receiving the authorization.
- I should retain a copy of this authorization form.

Signed:______________________________Print Name:___________________Date:_________
Signature of individual, parent on behalf of minor or legal representative

If signed by a legal representative, relationship to individual: _____________________________________
Please provide representative documentation, e.g., Power of Attorney, Health Care Surrogate or Guardianship papers

Please mail this completed Authorization to Release Medical Information form to 1) the person requesting the form, or to 2) GE Benefits Center, PO Box 60040, Ft Myers, FL 33906, or fax to 3) 1-239-275-2457

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