



AUTHORIZATION FOR RELEASE OF MEMBER INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the person/organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy laws, rules and regulations. I also understand that the person/organization authorized to receive the information may re-disclose the information and then the information will no longer be protected by federal privacy laws, rules and regulations. **I understand that this form must be complete to be considered valid.**

Member name: _____ **ID Number:** _____

Specific description of information to be disclosed. Please check the appropriate boxes:

- Physician Hospital Pharmacy Dental Other: _____
- Mental Health Substance Abuse

Requested dates(s) of service: From _____ to _____

Description of how the information will be used and why you would like us to disclose your information: _____
Initials _____

The member or the member's representative must read and initial the following statements:

I understand that this authorization will expire on / / (DD/MM/YEAR) **Initials:** _____

I understand that I may revoke this authorization at any time by notifying Independent Health in writing. If I do revoke this authorization, my revocation will not have any affect on any actions Independent Health took before they received my revocation. **Initials:** _____

Signature of member
(for whom the above information is being released)

Printed name of member

Signature of member's authorized representative
(if authorized by the above member)

Printed name of member's authorized representative

Relationship to the member: _____

Today's Date: _____

I declare that the person who signed this document is personally known to me. He or she has signed the document in my presence.

Witness #1
Address

Witness #2
Address

Representative's authority to act on behalf of member (i.e., Health Care Proxy, Legal Guardian, Parent of minor child): _____

[This Section To Be Completed By Independent Health]

Persons/organizations providing the information:

Persons/organizations receiving the information:

Independent Health Association, Inc. by: _____

Brief description of Information to be Disclosed (note: must identify whether mental health, alcohol and substance abuse information is being disclosed): _____

You may refuse to sign this authorization but then Independent Health will NOT be able to release your information. You may revoke this authorization at any time by writing to Independent Health's Member Services Department at: 511 Farber Lakes Drive, Buffalo, NY 14221. A copy of your signed authorization will be available to you. Signing or not signing this form will NOT affect any treatment, payment, enrollment or eligibility for benefits decisions made by Independent Health.

**Usted puede solicitar una traducción oral de todos los materiales escritos si la necesita.
(Oral translation of written materials available upon request.)**