Authorization for Release of Protected Health Information

I, _____, hereby authorize Self Insured Plans LLC (SIP) and/ or its subsidiaries to share the following Protected Health Information (PHI) concerning me:

- ❑ Name, address, age, gender and other identifying information.
- ❑ Health care coverage information, and
- ❑ Past, present and future claims information.

I understand that my PHI may be shared with the people listed below on this form and that they may not be required to comply with federal health information privacy laws and may use, and further disclose, any of my PHI they receive.

Authorized Representative(s) of _____(Member's Name):

_____ _____

_____ _____

This authorization is voluntary and is not a condition of enrollment in a health plan, eligibility for benefits or payment of claims.

Signature

Participant Signature: _____ Date: _____

Social Security Number: _____

If someone else is signing this authorization form on behalf of the participant, please provide the following information:

*Legal Representative: _____

Date Signed: _____

Relationship to the participant: _____

Copy of Authorization

Please keep a copy of your signed authorization. A photocopy is as valid as the original.

Right to Revoke

I understand that I may cancel my authorization at any time by giving written notice to the office listed above. I further understand that cancellation of my authorization will not effect any action taken by SIP or its subsidiaries prior to receiving my written notice of cancellation.

***Note: Please provide written documentation to support your status as a legal representative and/or guardian.*