HealthComp

Email completed form to:
CustomerServe@HealthComp.com

HIPAA Authorization to Disclose Health Information

(Protected Health Information includes an individual's health information that relates to their past, present or future physical or mental health and provision and payment of health care to an individual.)

I give permission for any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility or other healthcare provider that has provided payment, treatment or services to me or on my behalf and/or their business associates to give out Protected Health Information (PHI) pertaining to me or any of my dependents listed below. The information that may be requested by Member Services for the purpose of assisting me with questions, obtaining health care services, and approval or payment for health care services includes enrollment, claims payment, medical records, and/or managed care information.

Employer name (required): _____

Member name (required): _____

SSN #: _____ Date of birth: _____

Phone #: _____

Address: _____

Name of health insurance carrier: _____

Phone #: _____ Policy #: _____ Group #: _____

Dependents to whom this may apply

Dependent: _____ Date of birth: _____ Relation to member: _____

Dependent: _____ Date of birth: _____ Relation to member: _____

Dependent: _____ Date of birth: _____ Relation to member: _____

Dependent: _____ Date of birth: _____ Relation to member: _____

☐ Check if authorization includes information on mental health or substance abuse.

1. I understand that the information disclosed based on this authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal privacy regulations.
2. I understand that Member Services provides information and administrative services and does not provide or replace health insurance coverage, provide medical care, or recommend treatment.
3. I understand that I may revoke or withdraw this authorization at any time by sending a written notice to:

   Member Services
   P.O. Box 1590
   Covington, LA 70434

   and it will be effective for future uses and disclosures of the information described above. It will not have any effect on information already used or given out.
4. This authorization expires (it is required you identify a specific date or event): _____

_____ _____
Signature of individual or individual's representative (required) Date (required)

_____ _____
Printed name of the individual's representative and relationship (if the patient has designated an Authorized Representative, their signature is required)

Authority to act on behalf of individual