MUNICIPAL HEALTH BENEFIT PROGRAM

Authorization to Disclose Health Information

P.O. BOX 188, NORTH LITTLE ROCK, AR 72115

Fax: 501-537-7252

This form is **OPTIONAL**. By completing this form, a covered individual may allow someone other than themselves or their providers access to their Private Health Information (PHI). **PLEASE PRINT**

Name of Policy Holder: _____ID#/SSN: _____

Group/Employer Name: _____

I _____(name), do hereby give authorization to the Municipal Health Benefit Program (Plan) permission to disclose any and all Private Health Information (PHI) to the individual name below:

_____/_____

Print Name Relationship to Member

(1) I understand that I have the right to revoke this authorization at any time in writing and present my written revocation to the Program at the address listed above. I understand that the revocation will not apply to information already released in response to this authorization. I understand the revocation will not apply to the Program or their lawyers when the law provides the Program with the right to contest a claim made under Program coverage. Unless revoked, this authorization will expire on the following date, event, or condition: _____, or at the termination of my employment.

(2) I understand that this form is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment or proper claims payment while I am covered under the Program. I understand that I may inspect or copy the information to be used or disclosed as provided in CFT164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by the federal confidentiality rules. If I have questions regarding the disclosure of my health information, I may contact the Program's designated representative.

Signature: _____ Date: _____

Witnessed by: _____ Date: _____

_____

Print Name