AR BENEFITS Authorization to Release Information

This form is used to release your protected health infomation as required by federal and state privacy laws. Your authorization allows the Employee Benefits Division (EBD) to release your protected health information to a person or organization that you choose. You can revoke this authorization at any time by submitting a request in writing to EBD or filling out the Authorization to Revoke Release of Health Information form. Revoking this authorization will not effect any action taken prior to receipt of your written request.

Member Information (individual whose information will be released)

Name: _____ Member ID #: _____

Home Number: _____ Cell Number: _____ Birth date: _____

Address: _____ City: _____ State: _____ Zip: _____

I authorize EBD to release my protected health information as described below

Recipient (Person or Organization that will receive your information)

Person's Name or Organization: _____

Address: _____ Home Number: _____

Person's Name or Organization: _____

Address: _____ Home Number: _____

Description of the Information to be Released

☐ Entire Health Record

☐ Other, please describe _____

This authorization will expire (Check ONLY ONE Box)

☐ When I revoke this authorization

☐ Upon the following date, event, or condition _____

If I fail to select an option above, this authorization will expire in twelve (12) months from the date of this signing.

I understand that this authorization to release information is voluntary and is not a condition of enrollment in the ARBenefits Health Plan, eligibility for benefits, or payment of claims. I also understnad that once the information is disclosed pursuant to this authorization, it may be disclosed by the recipient and the information may not be protected by federal privacy regulations. I understand that the information in my health record may include information relating to sexually transmitted diseases, behavioral or mental health services, and treatment fo alcohol and drug abuse.

By signing below, I authorize the release of my protected health information as described above.

_____ _____

Signature of Member or Legal Representative Date

_____

Printed Name of Member or Legal Representative

MAIL OR FAX FORM AND ACCOMPANYING DOCUMENTS TO:

Department of Transformation and Shared Services - Employee Benefits Division

ATTN: Eligibility Department - PO Box 15610, Little Rock, AR 72231-5610 - FAX: 501-683-0983