



HSA HEALTH INSURANCE COMPANY AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Full Name _____

ID# _____

Date of Birth _____

I authorize HSA Health Insurance Company to disclose the following information:

- | | |
|---|--|
| <input type="checkbox"/> Enrollment, eligibility, benefit information | <input type="checkbox"/> Claims, claim status, and claim history |
| <input type="checkbox"/> Medical records and diagnosis | <input type="checkbox"/> Premium and billing information |
| <input type="checkbox"/> Alcohol/substance abuse* | <input type="checkbox"/> Appeal |
| <input type="checkbox"/> Preauthorization | <input type="checkbox"/> Other _____ |

This information may contain sensitive data, including data related to treatment of sexually transmitted diseases, HIV/AIDS, mental health, and reproduction or contraception (including prenatal care and abortion).

I authorize HSA Health Insurance Company to disclose the information identified above to the following person(s) or entity(ies):

Name _____ Name _____

Relationship _____ Relationship _____

Address _____ Address _____

Phone () _____ Phone () _____

1. The purpose of this disclosure is: to assist me with my health plan Other _____

2. This authorization **will expire two years from the date signed** unless a shorter time frame is requested here:
 (mm/dd/yyyy) _____

I may cancel this authorization at any time by sending written notice to HSA Health Insurance Company, PO Box 709718, Sandy, UT 84070. Cancellation of this authorization will not affect any actions taken by HSA Health Insurance Company before receiving my cancellation notice. I understand completing this authorization is not a condition to receive treatment, payment, enrollment, or eligibility. HSA Health Insurance Company is not responsible for any action taken by an authorized recipient of my protected health information. I am aware that once HSA Health Insurance Company discloses my information to an authorized recipient the privacy protections provided by law may no longer apply.

▶ _____
Signed _____ Dated _____

If you are signing this authorization on behalf of another individual, please complete the following and attach documentation demonstrating your authority to act on behalf of the individual (e.g., power of attorney, guardianship, conservatorship, etc.).

Name of Personal Representative (please print) () Phone _____ Relationship _____

▶ _____
Signature of Personal Representative _____ Dated _____

* **NOTE:** I understand that my substance abuse records are protected under Federal law (42 CFR Part 2) and cannot be disclosed without my written consent unless otherwise provided for in 42 CFR Part 2. I also understand that I may cancel this approval at any time, as described above.

Please return completed form to HSA Health Insurance Company: PO Box 709718, Sandy, UT 84070