ADVANTAGE Health Solutions, Inc. sm
AUTHORIZATION REQUEST TO USE OR DISCLOSE
Protected Health Information

You may refuse to sign this authorization

Purpose: This form is used to request an individual's authorization for ADVANTAGE to use or disclose protected health information only for the purpose(s) stated on this form. **This form may not be used to obtain authorization for use or disclosure of psychotherapy notes.**

No Conditions: This authorization is voluntary. We will not condition our payment activities in connection with your claims, your enrollment in our health plan, or your eligibility for benefits on you giving this authorization.

Effect of Granting this Authorization: The protected health information described below may be disclosed to and/or received by persons or organizations that are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws. They may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws.

THIS AUTHORIZATION FORM MUST BE COMPLETED IN FULL IN ORDER FOR THE AUTHORIZATION TO BE VALID

Name: ____

Address: ____

Telephone #: ___________________________________

Subscriber Number: _____________________________

Date of Birth: ___________________

Please describe what protected health information you are authorizing ADVANTAGE to Use or Disclose.

NOTE: You have the right to inspect and/or copy the protected health information described above.

Please describe the purpose why you are authorizing ADVANTAGE to Use or Disclose your protected health information described above.

Please confirm you are authorizing ADVANTAGE to Use or Disclose to others your Protected Health Information noted above:

Yes ☐
No ☐

Please list who can receive and use your Protected Health Information you described above:

Expiration: This authorization will expire (complete one):

- ❑ On _____/_____/_____
- ❑ On occurrence of the following event (this event must relate to the individual or to the purpose of the use and/or disclosure being authorized):

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact Office listed below. I understand that revocation of this authorization will not affect any action you took in reliance on this authorization before you received my written notice of revocation.

Contact Office:	**ADVANTAGE Health Solutions, Inc.**[sm]		
	Attn: Compliance Department		
Address:	**9045 River Road, Suite 200**		
	Indianapolis, IN 46240		
Telephone:	**1-877-901-2237 (Hearing Impaired 1-800-743-3333)**	Fax:	**317-536-3710**

SIGNATURE – YOU MAY REFUSE TO SIGN THIS AUTHORIZATION:

I, ____, have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization that ADVANTAGE may use and/or disclose to the persons and/or organizations named in this form the protected health information described in this form for the purposes stated in this form.

I understand that, if the person or organizations I authorized to receive and/or use the protected health information described in this form are not health plans, covered health care providers, or health care clearinghouse subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

Signature: ______________________________ **Date:** ________________

Printed Name: ______________________________

If this authorization is signed by a **personal representative** on behalf of the individual, complete the following:

Personal Representative's Name: ______________________________

Relationship to Individual: ______________________________

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT