



Authorization for Release of Information

Your medical information is considered private and confidential. By completing this form, you are permitting the _____ (Group Health Plan Name) health and/or welfare plan to provide information to the person(s) that you specify. The form is designed to protect your private and confidential medical information by allowing that person(s) whom you designate to access your information.

_____ (Group Health Plan Name) health and/or welfare plan will not release information pertaining to mental illness, alcohol or substance abuse treatment or HIV/AIDs because federal and state law requires special disclosure forms for release of this type of medical information. This information may only be released to you or to your legal representative (such as a legal guardian or a health care power of attorney) without the special disclosure form.

I authorize the person(s) below to receive my individually identifiable medical information, including my benefits. I understand that this may include protected health information and other information protected under federal and state law. By signing this form, I release _____ (Group Health Plan Name) health and/or welfare plan and Employee Benefit Management Corp. (EBMC) from any liability in connection with the release of my individually identifiable information to the person(s) designated below.

Information is Authorized to be Released for the following Covered Person(s): _____

Social Security Number of Covered Person(s): _____

Employee Identification Number on Card: _____

Covered Person's Signature: _____ Date: _____

Name of Person Authorized to receive information: _____

Relationship to Covered Person(s): _____

Address of Person being Authorized: _____

Telephone Number of Person being Authorized: _____

the above authorization is effective until revoked by sending a request to the address below

Please Mail this Form to:

EBMC
Attention: Enrollment
4789 Rings Road
Dublin, Ohio 43017