

AUTHORIZATION FOR DISCLOSURE OF HEALTH PLAN INFORMATION

Purpose: This form is used to authorize use or disclosure of protected health information or for another person to disclose protected health information to us for the purpose stated.

1. I hereby authorize Stirling Benefits, Inc., health plan administrator, to disclose the following information from the health records of:

Name of Employer Group: _____ Participant ID#: _____

Plan Participant Name: _____ Date of Birth: _____

Address: _____ Telephone: _____

2. This Information Is To Be Disclosed To: _____

For The Purpose of: *Specifically describe the protected health information you are authorizing to be used and/or disclosed:*

3. I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this Authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition or one year after termination from the plan.

This authorization will expire on ____/____/____

4. By signing below, I acknowledge that:

- This Authorization is Voluntary
- The protected health information described may be disclosed to and/or received by persons or organizations that are not health plans, covered health care providers or health care clearinghouses that are 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.
- Stirling Benefits, Inc. employees and officers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signed:

_____ **Plan Participant or Legal Representative***

_____ **Date**

_____ **Relationship to Member**

_____ **Date**

_____ **Signature of Witness**

_____ **Relationship to Member**

_____ **Date**

***If necessary, please include copy of power of attorney.**

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

**Include this authorization in the individual's records.
Send a copy to the Privacy Official.**