Authorization for Use or Disclosure of Protected Health Information

Patient Name			**Date of Birth**		
Street Address					
City		**State**		**Zip Code**	

I, _____ hereby authorize Marin Benefits Administrators to release any and all medical information that pertain to me to the following individual(s):

name of patient

Name		**Phone #**		**Relationship**	
Name		**Phone #**		**Relationship**	
Name		**Phone #**		**Relationship**	
Name		**Phone #**		**Relationship**	

1. I authorize Marin Benefits Administrators to contact the individual(s) listed above to convey any pertinent information to me.
2. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
3. I understand that the medical information released may include any and all information concerning treatment of medical history, mental illness, alcohol/drug abuse, and HIV/AIDS information.
4. You or your representative can revoke this authorization or change the name(s) of the individuals to whom information is to be released upon written request. If you revoke, it will not affect information disclosed before the receipt of the written request.
5. Once this health information is disclosed, how the recipient further discloses it may no longer be protected under federal privacy law (HIPAA) or state law.
6. This authorization shall remain in effect for one year from the date of signature unless a different date is specified here.

_____
Date

A copy of this authorization is as valid as an original. I have the right to receive a copy of this authorization.

Date	**Signature of patient or personal representative**	**Printed name of patient, or personal representative and relationship to patient**

Marin Benefits Administrators
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