



PRIMARY HEALTH PLAN
AUTHORIZATION FOR THE USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

MEMBER NAME: _____ MEMBER #: _____ - ____

I hereby authorize the use and disclosure of my Protected Health Information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

- 1. Person(s)/organization(s) authorized to receive the information, and the relationship of such person(s)/organization(s):
Individual/Organization Relationship to Member

Blank lines for entering individual/organization and relationship to member.

- 2. The information will be used/disclosed for the following purposes: Circle One
To obtain information regarding health claims ALL SPECIFIC
To obtain benefit/eligibility information ALL SPECIFIC
To obtain information regarding referrals and precertification ALL SPECIFIC
Other (specified below) ALL SPECIFIC

Blank lines for specifying other purposes.

- 3. Specific description of information that may be used/disclosed:

Blank lines for describing information to be used/disclosed.

- 4. I understand that I may revoke this authorization at any time by notifying Primary Health Plan in writing; however, the revocation shall not apply to any information already disclosed by Primary Health Plan in reliance upon this authorization.

- 5. This authorization expires on _____.

Signature of member or member's representative

Date

Printed name of member or member's representative

Relationship to member or Authority to act for member

SEE REVERSE SIDE ON HOW TO COMPLETE THIS FORM

How To Complete This Form

1. List the first and last name of the individual or organization, and the relationship of that individual or organization, whom you authorize to receive your Protected Health Information. For example, John Doe-Father of Member; Jane Smith-American Ins.- Insurance Representative.
2. In stating the purpose for the disclosure, please check all that apply. If you do not select “specific” information to be disclosed, we may disclose all information under the category you select.
3. If you wish to only authorize specific information, please indicate under paragraph 3 the **specific** information you authorize to be disclosed, i.e. specific claims, including dates, referral/precertification information, and benefit/eligibility information.
4. Send completed forms or your request for a revocation of the authorization to:

Primary Health Plan
Attn: Enrollment
P.O. Box 5679
Boise, ID 83705

Or fax to (208)433-4600, Attn: Enrollment Dept.

5. If you wish to have this authorization expire on a specific date, please indicate in paragraph 5. Otherwise, the authorization will be considered open-ended and will not expire.
6. If a dependent is 18yrs. of age or older, they must sign this form personally. If under 18, the main policyholder must sign.
7. Spouses cannot sign for each other.
8. A separate form must be filled out for each member on the policy that is over 18yrs. of age.
9. Your member # is 11 digits (9+2 digit identifier). Please reference your ID card for the correct number. Your group # is only 6 digits long, and is not necessary for this form.