

## AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I, \_\_\_\_\_, **[Individual Name]** hereby authorize the SMWIA Local 49 Family Health Plan (the "Plan") to disclose my health information as described in this authorization. This authorization shall also apply to the following designated business associate of the Plan (to the extent the business associate maintains the information that is the subject of this Authorization):

\_\_\_\_\_ (*insert name of business associate authorized to release information pursuant to this authorization*).

(1) *Specific person/organization (or class of persons) to whom the Plan is authorized to disclose the information:*

\_\_\_\_\_

(2) *Specific description of the information to be disclosed by the Plan:*

\_\_\_\_\_

(3) *Right to Revoke:* I understand that I have the right to revoke this authorization at any time by notifying the Plan in writing at 2400 West Dunlap, Suite 250, Phoenix, Arizona 85021-2811. I understand that the revocation is only effective after it is received by the Plan. I understand that any use or disclosure made prior to the revocation of this authorization will not be affected by the revocation.

(4) *Potential for Redisclosure:* I understand that after this information is disclosed, federal law might not protect it, and the recipient might redisclose it

(5) *Right to Copy:* I understand that I am entitled to receive a copy of this Authorization.

(6) *Expiration of Authorization.* This authorization will expire **[choose and complete one]**.

On the \_\_\_\_ day of \_\_\_\_\_, 201\_\_.

Upon the occurrence of the following event: \_\_\_\_\_

(7) *Voluntary:* I understand that I am under no obligation to sign this form. I acknowledge I am voluntarily signing this form to release my health information to the party I have designated.

