



AUTHORIZATION FOR RELEASE OF HEALTH, MEDICAL, AND CLAIM INFORMATION

Vernon County

This form will be used to collect detailed medical claim information about the patient listed. This form **must be completed in full by the patient or their legal guardian** for all authorizations.

*This form only needs to be completed by the patient if they **marked any box in the "Medical History Information" section** of the GBS Medical Questionnaire.*

PATIENT INFORMATION

Legal Name: _____ Daytime Phone: _____

Social Security Number: _____ Date of Birth: _____

Home Address: _____
Street City State Zip Code

PROVIDER INFORMATION

Please identify the medical facility or physician who provided the medical service(s) for any conditions checked on the GBS Medical Questionnaire. Additional space is available on the back of this form.

Provider Name: _____ Daytime Phone: _____

Provider Name: _____ Daytime Phone: _____

AUTHORIZATION OF RELEASE

AUTHORIZATION AND REVOCATION

- 1. I understand that this authorization will expire two (2) years from the date shown on this form. **Initials:** _____
- 2. I understand that I may revoke this authorization at any time by notifying the healthcare provider in writing. **Initials:** _____
- 3. I understand that if I do revoke this authorization that it will not have any effect on any actions the healthcare provider took before they received the revocation. **Initials:** _____

COPIES OF PATIENT INFORMATION

- 1. I understand that I may review and receive or make a copy of the information described on this form if requested. **Initials:** _____
- 2. I understand that I may retain a copy of this form after I have signed it. **Initials:** _____

INFORMATION TO BE RELEASED

This form releases the detailed health, medical, and claim information associated with the medical service(s) provided to the patient listed above.

INFORMATION RECIPIENTS

The patient's health, medical, and claim information will be received by Group Benefit Services (GBS) and its managed care organization(s).

USE AND DISCLOSURE OF INFORMATION

The purpose for the use or disclosure of the patient's health, medical, and claim information is for a **health insurance claim investigation and/or negotiation(s)**. The health plan or healthcare provider requesting the authorization **will not receive financial or in-kind compensation** in exchange for using or disclosing the health information described above.

PATIENT AUTHORIZATION

I hereby authorize the use and disclosure of all my individually identifiable health, medical, and claim information as described above. I understand that this authorization is voluntary. I also understand that if the organization(s) authorized to receive this information is not a health plan or healthcare provider that the released information may no longer be protected by federal privacy regulations.

Signature: _____ Date: _____