



ASSOCIATED BENEFITS CORPORATION

AUTHORIZATION

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

SECTION A: Psychotherapy notes.

Check if this authorization is for psychotherapy notes.

If this authorization is for psychotherapy notes, you must not use it as an authorization for any other type of protected health information.

SECTION B: Individual authorizing use and/or disclosure.

Name: Address: Telephone: E-mail: Identification Number: Social Security Number:

SECTION C: The use and/or disclosure being authorized.

Protected Health Information to Be Use and/or Disclosed: Specifically and meaningfully describe the protected health information you are authorizing be used and/or disclosed:

Entities Authorized to Use or Disclose: Name or specifically describe the persons and/or organizations (or the classes of persons and/or organizations), including us, who you are authorizing to make use of and/or to disclose the protected health information described above:

Entities Authorized to Receive: Name or specifically identify the persons and/or organizations (or the classes of persons and/or organizations), including us, to whom you are authorizing the disclosure and subsequent use of the protected health information described above:

Purpose of this Authorization:

- At request of individual. For the following purposes:

No Conditions: This authorization is voluntary. We will not condition your enrollment in a health plan, eligibility for benefits or payment of claims on giving this authorization.

Effect of Granting this Authorization: The protected health information described below may be disclosed to and/or received by persons or organizations that are not health plans, covered health care providers or health care clearinghouses 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.

**SECTION D: Expiration and revocation.**

Expiration: This authorization will expire (complete one):

- On \_\_\_\_/\_\_\_\_/\_\_\_\_
- On occurrence of the following event (which must relate to the individual or to the purpose of the use and/or disclosure being authorized):

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Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact Office listed below. I understand that revocation of this authorization will *not* affect any action you took in reliance on this authorization before you received my written notice of revocation.

Contact Office: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_

Address: \_\_\_\_\_

**INDIVIDUAL'S SIGNATURE.**

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this authorization, and I understand that, by signing this form, I am confirming my authorization of the use and/or disclosure of my protected health information, as described in this form.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Individual: \_\_\_\_\_

**Send completed and signed form to:**  
**Associated Benefits Corporation**  
**Privacy Office**  
**P.O. Box 71039**  
**Des Moines, IA 50325-0039**