Argonne NATIONAL LABORATORY

HIPAA AUTHORIZATION FOR RELEASE OF INFORMATION

I. Information about the Use or Disclosure

I hereby authorize the use and disclosure of protected health information as described below.

Patient's full name: _____ Date of Birth: _____

Persons/organizations (or class of persons/organizations) authorized to **use and disclose** the information:
Argonne National Laboratory Employee Benefits Department

Persons/organizations (or class of persons/organizations) authorized to **receive and use** the information:

_____

_____

_____

Specific description of information to be used and disclosed (including relevant date(s) and conditions):
Health claim details pertaining to authorized recipient's inquiry, including, but not limited to: dates of service, provider of service, diagnoses, prescription drug dosage, claim determination

Specific purpose of the disclosure: Health plan claim resolution

Will the health plan/employer requesting the authorization receive financial or in-kind compensation or remuneration in exchange for using or disclosing the health information described above? No

This authorization will expire (Check one):

☐ One year from date of signature

☐ When I, dependent child, turn age 26

☐ Other specified date: ____/____/____

II. Important Information about Your Rights

I understand that:

- This authorization is voluntary and I may refuse to sign it.
- I may revoke this authorization at any time prior to its expiration date by sending a written revocation notice to each entity that I previously authorized to disclose health information. The revocation will not have any effect on any actions that the entity took before it received the revocation notice.
- I am not required to sign this authorization as a condition to receiving treatment or payment for health care; enrolling in a health plan; or establishing eligibility for benefits.
- The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving person or organization and, upon re-disclosure, no longer be protected by federal privacy laws.

III. Signature of Patient or Patient's Representative *(Form must be completed before signing)*

_____ _____

Signature of patient or patient's personal representative **Date**

Relationship to the insured: _____

If the form is signed by a personal representative instead of the patient, complete the following information and attach legal authority documentation:

Printed name of the patient's personal representative: _____

Relationship to the patient, including authority to act as personal representative: _____