Authorization to Release Protected Health Information (PHI)

This form is used for the authorization to use or disclose protected health information. Such authorization is required by the Health Insurance Portability and Accountability Act (HIPAA).

By completing and signing this form, I, or my legal representative, agree to allow OneShare Health to share my protected health information (PHI) with the person(s) and/or organization(s) listed below. I understand this authorization is voluntary and made to confirm my directions. I understand that once the information is disclosed, it may re -disclosed and no longer protected by federal privacy regulations. I hereby give permission for the disclosure of my personal health information (PHI) in the manner described below.

Name of Member or Individual	
First Name:	Last Name:
Mailing Address:	
City, State, and Zip Code:	
Phone Number:	Date of Birth:

Authorization Statement:

I hereby authorize the disclosure of my Protected Health Information when requested by me, or notification in the event of a medical emergency, to the individuals named below. I understand this authorization is voluntary and that refusal to sign will not affect my ability to obtain and retain membership.

Authorized Parties and Relationship	
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:

I allow the above-mentioned person(s) to receive information related to **(check one):**

- ☐ Disclose my **complete** health record (including but no limited to diagnosis, labs, tests, treatment, and billing for all conditions)
- ☐ Disclose and/or allow changes to **only** the following portions of my health record (check as appropriate):
  - ☐ Billing Records and Membership Records
  - ☐ Change/Updated of Record
  - ☐ Mental Health Records
  - ☐ Alcohol/drug abuse treatment
  - ☐ Communicable diseases
  - ☐ Other:

Effective Time Period:

This authorization is valid and shall be effective until _____ (date or event), unless cancelled prior. If this field is blank, the authorization expires **one year** from the date of the signature below.

Right to Revoke:

I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person(s) or anization named above. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

Signature of Authorization:

I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by 45 C.F.R. § 164.502(a)(1).

Signature of Member or Legally Authorized Representative **Date**