

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ (member name) hereby authorize Medi-Pak Advantage, their directors, officers, employees and agents, to disclose to _____ (name of person(s) or entity to receive information) the following information (select one):

_____ All information or data in any form, whether oral, written, electronic, video, or computer data, which relates to or references the named member. The information which I hereby authorize to be disclosed shall include, but shall not be limited to any information showing, relating to or arising from: (i) any benefit claims, or the processing, payment, denial or appeal of such claims; or (ii) the services provided by Arkansas Blue Cross and Blue Shield; or (iii) any medical records, notes, or documents of any kind; or (iv) any communications, notes or statements of any person or entity regarding or relating to any of the foregoing.

_____ Only specific information to include _____

Purpose of the request:

(Please state a purpose of the request. If you do not wish to state a purpose, please state, "At the request of the individual.") _____

Right to Revoke: I understand that I have the right to revoke this authorization at any time by providing written notice to either the person at Arkansas Blue Cross and Blue Shield who obtained this authorization from me (at the address below) or to an officer of Arkansas Blue Cross and Blue Shield that I intend to revoke the authorization. I understand and agree that this authorization shall apply to all information disclosed by Arkansas Blue Cross and Blue Shield prior to the time that my written notice of revocation is actually received by either the person who obtained it from me or an officer of Arkansas Blue Cross and Blue Shield, as referenced above.

This authorization shall remain valid and effective until such time as I have delivered written notice to Arkansas Blue Cross and Blue Shield (at the address below) or until _____ (Specify a date or event).

I understand that after this information is disclosed, federal law might not protect it and the recipient might re-disclose it.

I understand that I am entitled to receive a copy of this authorization upon request.

I understand that payment or eligibility will not be conditioned on receipt of this authorization.

Signature

Date Signed

Name – Printed

Medi-Pak Advantage I.D.#

Personal Representative: If a personal representative executes this form, that Representative warrants that he or she has authority to sign this form on the basis of: _____.

Completed Form may be mailed to:

Medi-Pak Advantage Privacy Office, P.O. Box 3835, Scranton, PA 18505