

**AUTHORIZATION TO RELEASE INFORMATION**

This form is to be completed by the Patriot Healthcare member who is authorizing that their personal health information can be accessed by the Patriot Healthcare subscriber.

Please complete this form and mail it to Attention: Eligibility Supervisor, Patriot Healthcare, P.O. Box 2000, Exeter, NH 03833 or fax to 603-773-4410.

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**SECTION A: The individual (or the Individual's Personal Representative) confirming the authorization.**

I authorize the use and/or disclosure of my protected health information as described in Section B below. I understand this authorization is voluntary and made to confirm my direction.

I understand that, if the persons or organizations I authorize in Section B below to receive and/or use the protected health information described below are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws, they may further disclose my protected health information and it may no longer be protected by federal health information privacy laws.

Member/Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Participant ID Number: \_\_\_\_\_ Telephone: \_\_\_\_\_

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

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**SECTION B: The Entity authorized to disclosure and purpose for authorization.**

The purpose of this authorization is to provide a subscriber with the ability to view their spouse's online claims and/or their dependent(s)' online claims. Patriot Healthcare, or authorized partners, is the entity that will disclose personal health information and the subscriber is the entity that will receive the personal health information.

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**SECTION C: Revocation.**

**Right to Revoke:** I understand that I may revoke this authorization at any time by giving written notice of my revocation to Patriot Healthcare, P.O. Box 2000, Exeter, NH 03833. I understand that my revocation will be effective when Patriot Healthcare receives it and that my revocation of this authorization will *not* affect any action Patriot Healthcare took in reliance on this authorization before receiving my written notice of revocation.

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**SECTION D: Conditioning.**

Payment, treatment, enrollment or eligibility for benefits may not be conditioned on the signing of this authorization unless this authorization is for the purposes of the following:

1. Research-related treatment
2. Determinations relating to underwriting or risk taking prior to enrollment in the health plan
3. Creating protected health information solely for disclosure to a third party

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**SECTION E: Signature.**

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my directions to Patriot Healthcare. I understand that, by signing this form, I am confirming my authorization that Patriot Healthcare may use and/or disclose to the persons and/or organizations named in this form the protected health information 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/Authority to act as Personal Representative of Individual: \_\_\_\_\_

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.