



**HIPAA Medical Authorization Form
Authorization for Release of Medical Records and Reports**

I hereby authorize any health care providers, physicians, hospitals, clinics and institutions, medical facilities, mental health clinics, mental health hospitals, pharmacies, and insurance companies to release all existing medical records and information regarding my medical care, treatment, physical/medical condition, and medical expenses relating to past, present and future treatment to Preferred Medical Plan, Inc. (PMP) or its reinsurer.

The purpose of this authorization is in connection with PMP's determinations regarding eligibility, underwriting, enrollment, benefits, claims payment, and case coordination.

This authorization includes information regarding the diagnosis and treatment of drug, alcohol, Acquired Immune Deficiency Syndrome (AIDS), and psychiatric and psychological disorders, except Psychotherapy Notes as defined by the Health Insurance Portability and Accountability Act, 45 CFR 164.501, which requires a separate authorization.

I understand that:

1. Any health care provider disclosing the above requested information may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.
2. PMP may condition my enrollment in the health plan or my eligibility for benefits on my execution of this authorization if requested by PMP prior to enrollment and sought for PMP's eligibility or enrollment determinations relating to underwriting.
3. This authorization can be revoked by providing written notice to PMP or to the above listed entities, except to the extent that action has been taken in reliance on this authorization.
4. Protected health information disclosed pursuant to this authorization is subject to re-disclosure in a manner that will not be protected by HIPAA regulations.
5. A photocopy of this authorization shall be considered as effective and valid as the original.
6. This authorization will remain in effect for a period of one (1) year from the date below or until the date my coverage ends with PMP, whichever comes later.
7. I am entitled to a copy of the completed authorization form.

Signature of Member/Applicant or Representative

Date

Printed Name of Member/Applicant or Representative

Description of Representative's Authority