APEX
Health Solutions℠

AUTHORIZATION FORM FOR DISCLOSURE OF MEMBER INFORMATION
(Must be complete)

I, _____ *(print member full name)*, hereby authorize the disclosure of my Protected Health Information (PHI) as described below.

1. This authorization was completed by:

   ☐ The Member

   ☐ The Member's Representative: *(please print name)* _____

2. **If you are completing this form as the Member's Legal Representative**, describe the scope of your authority to act on the member's and attach documentation of such authority (examples include Power of Attorney or Letter of Guardianship):

   _____

   _____

3. Protected member information to be released or disclosed: *(select one)*

   __ ALL INFORMATION: includes clinical (diagnosis, treatment), claims, billing and coverage

   __ LIMITED INFORMATION: *(specify)* _____

   _____

   The following information requires special authorization to disclose. Initial your selection(s) you wish to be disclosed:

   _____ Mental/behavioral health
   _____ Substance Abuse
   _____ HIV/AIDS
   _____ Reproductive Health/Sexually Transmitted Disease
   _____ Genetic Testing

4. Apex Health Solutions may release my Personal Health Information (PHI) as detailed in #3 above to the following person(s): ***(Please provide name, address and phone number for each person)***

   _____

   _____

   _____

   _____

5. Purpose of disclosure:

   This authorization will allow Apex Health Solutions to disclose your PHI (as limited in Item #3) to the individual(s) you identify in Item #4. If there is another purpose for which you wish Apex Health Solutions to disclose your PHI, please indicate the purpose here:

   _____

   _____

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6. This authorization will expire: *(select one)*

   ☐ When Coverage Ends.

   ☐ Other [**You must enter a specific date or specific event**] _____

7. As described in the Notice of Privacy Practices of Apex Health Solutions, I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by Apex Health Solutions in reliance on this authorization, by sending a written revocation to **Compliance Dept., P.O. Box 3620, Akron, Ohio 44309**.

8. I understand that if the person or entity that receives PHI is not a health care provider or health plan covered by federal privacy regulations, the PHI may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations. Further, if the information is disclosed by the member's named representative, Apex Health Solutions will not be liable for such disclosures.

9. I understand that I am not required to sign this authorization form and not signing this form will not affect payment of claims by Apex Health Solutions. However, if I do not sign this authorization form, Apex Health Solutions will not provide information to anyone, except to a covered entity under HIPAA for the purpose of treatment, payment or operations.

If Completed by Member
Fill in the requested information below
Be sure to sign and date the highlighted areas

_____
Member's Name (print)

_____
Member's ID #

_____
Member's Signature

_____
Date

If Completed by Member's Legal Representative
If signing as Member's Legal Representative, you must provide documentation of your authority to act on member's behalf. (See #2 above)

_____
Name of Legal Representative, if applicable (print)

_____
Relationship of Legal Representative to Member

_____
Signature of Member's Legal Representative

_____
Date

Send the completed form to:

Apex Health Solutions
ATTN: Compliance Dept.
P.O. Box 3620
Akron, OH 44309