



**Authorization to Release Information**

This form is used to release your protected health information as required by federal and state privacy laws. Your authorization allows EBD (ARBenefits) to release your protected health information to a person or organization that you choose. You can revoke this authorization at any time by submitting a request in writing to EBD. Revoking this authorization will not affect any action taken prior to receipt of your written request.

**Member Information: (individual whose information will be released)**

Name: \_\_\_\_\_ Member ID #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone #: \_\_\_\_\_

**I authorize EBD (ARBenefits) to release my protected health information as described below:**

**Recipient: (Person or organization that will receive your information)**

Person's Name or Organization: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Person's Name or Organization: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone #: \_\_\_\_\_

**Description of the Information to be Released: (What type of information will be released)**

- Entire Health Record
- Other, please describe \_\_\_\_\_

**Expiration: (When this authorization will end)**

This authorization will expire (Check ONLY ONE Box):

- When I revoke this authorization.
- Upon the following date, event, or condition: \_\_\_\_\_

If I fail to specify an expiration date, this authorization will expire in twelve (12) months from the date of this signing.

*I understand that this authorization to release information is voluntary and is not a condition of enrollment in ARBenefits Health Plan, eligibility for benefits, or payment of claims. I also understand that once the information is disclosed pursuant to this authorization, it may be disclosed by the recipient and the information may not be protected by federal privacy regulations. I understand that the information in my health record may include information relating to sexually transmitted diseases, behavioral or mental health services, and treatment for alcohol and drug abuse.*

By signing below, I authorize the release of my protected health information as described above.

\_\_\_\_\_  
**Signature of Member or Legal Representative**

\_\_\_\_\_  
**Printed Name of Member or Legal Representative**

\_\_\_\_\_  
**Date**

<b>For EBD Use Only</b>
Member ID#: _____
Completed By _____