Authorization to Use or Disclose Protected Health Information (PHI)

Section 1. Who is the Patient?

Last Name: First Name: Middle Initial:

Subscriber Number from ID Card: Insurance Member's Name (L, F, MI) Date of Birth (MM/DD/YYY) Daytime Phone Number

Street Address City State Zip Code

I hereby authorize the use or disclosure of protected health information about the individual patient named above.

I am:
- the individual named above (complete Section 7 below to sign this form).
- a personal representative because the patient is a minor, incapacitated, or deceased (complete Section 8 below).

Section 2. Who will be Disclosing Information About the Individual?

The following person(s) or entity may use or disclose the information (Name a person, a class of persons (like "doctors who treated me in 2006"), or an organization, etc):

Name Phone Number (if known)

Street Address (if known) City, State and Zip Code (if known)

Section 3. Who will be Receiving Information about the Individual?

The information may be disclosed to (a person, a class of persons like "family members residing with me", or an organization):

Name Phone Number (if known)

Street Address (if known) City, State and Zip Code (if known)

Section 4. What Information about the Information will be Disclosed?

Please specify the type of medical, personal, behavioral health and/or substance abuse services information to be disclosed, including all relevant dates:

Section 5. What is the Purpose of the Disclosure?

Please give the reason the information is being requested or disclosed.

Section 6. What is the Expiration Date or Event?

This authorization must expire within 1 year, on either a specific date or upon a specific event. Please choose either:
- the following expiration date (no more than 1 year from today):
- the following specific event (needs to happen within 1 year):

Section 7. Signature of the Individual

Signature: ______________________________ Current Date

Section 8. Signature of Personal Representative (if applicable)

Signature: ______________________________ Current Date

Please describe your relationship to the individual and/or your legal authority to act on behalf of the individual in making decisions related to healthcare. You may be asked to provide us with the relevant legal document giving you this authority. Relationship to the individual (required).

Important Rights and Other Required Statements You Should Know

- ▲ You can revoke this authorization at any time by writing to **INDECS Corp., 1099 Wall Street W., Lyndhurst, NYJ 07071**. If you revoke this authorization, it will not apply to information that has already been used or disclosed.
- ▲ The information disclosed based on this authorization may be redisclosed by the recipient and may no longer be protected by federal or state privacy laws. Not all persons or entities have to follow these laws.
- ▲ You do not need to sign this form in order to obtain enrollment, eligibility, payment, or treatment for services.
- ▲ This authorization is completely voluntary, and you do not have to agree to authorize any use or disclosure.
- ▲ You have a right to a copy of this authorization once you have signed it. Please keep a copy for your records, or you may ask us for a copy at any time by writing to **INDECS Corporation, 1099 Wall Street West, Lyndhurst, NJ 07071.**
- ▲ If you have any questions about anything on this form, or how to fill it out, we can help. Please call INDECS Corporation Customer Services at (888) 4-INDECS.