Authorization to Release Certain Information under the HIPAA Privacy Act

Date: ______________________________

This is your authorization to discuss and /or provide to ______________________________ , any information requested concerning inquires about the status or payment of claims, inquiries or explanation of benefit summaries, to request copies and/ or the handling or filing of any claims.

This authorization is in effect as of ______________________________ , until rescinded by the Insured / Spouse / Dependent.

______________________________ ______________________________

Signature of Insured Mbr ID/ SSN

______________________________ ______________________________

Signature of Spouse/Dependent Mbr ID/ SSN

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Witness

www.paragonbenefits.com
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