

## Instructions for completing the Authorization Form

### **PHI - Protected Health Information**

**Individual Authorizing Disclosure:** Complete your name, address, phone number and at least one of the following: your group health plan number **or** your SSN.

**Entities Authorized to Use or Disclose.** This is where First Administrators, Inc. is authorized to release your PHI.

**Protected Health Information to be Used and/or Disclosed.** Indicate the PHI you would like released. Examples - all information or information pertaining to a specific date or accident. If the PHI relates to plan dependents' information, such as a spouse or children, identify them here by name and the information to be released, i.e "EOB's", etc.

**Entities Authorized to Receive.** This is where you would indicate the individuals and/or entities that you are authorizing to receive your PHI or the PHI of other plan dependents. **Identify persons by name.** For example, "my wife" or "my mother" is not acceptable.

**Expiration and revocation:** This section is optional. This authorization will expire upon termination of health plan coverage, or upon settlement of claims incurred while covered. If you want expiration to occur on a specific date or upon a specific action, such as settlement of a case, please enter the date or action.

**Individual's Signature:** This is where you give your written authorization. Please print your name on the blank line and sign and date the form.

CONFIDENTIAL



## Authorization

This form is used to authorize First Administrators, Inc. to disclose protected health information at the request of the individual.

### Individual Authorizing Disclosure

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Identification Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

### Use or Disclosure Being Authorized

**Entity Authorized to Disclose:** First Administrators, Inc.

**Protected Health Information to be Disclosed:** Specifically and meaningfully describe the protected health information you are authorizing to be disclosed:

\_\_\_\_\_  
\_\_\_\_\_

**Persons or Entities Authorized to Receive:** Name or specifically identify the persons and/or organizations (or the classes of persons and/or organizations), to whom you are authorizing the disclosure and subsequent use of the protected health information described above:

\_\_\_\_\_  
\_\_\_\_\_

**Effect of Granting this Authorization:** I understand that if the person or entity that receives the information requested is not covered by federal or state privacy laws, the information described above may be redisclosed and will no longer be protected by law.

**Prohibition of Redisclosure:** This form does not authorize the disclosure of medical information beyond the limits of the authorization. Where information has been disclosed from the records protected by Federal law for alcohol/drug abuse records or state law for mental health records, the Federal requirements (42 CFR Part 2) and state requirements (SDCL 27A-12) prohibit further disclosure without the specific written consent of the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

**No Conditions:** This authorization is voluntary. First Administrators, Inc. will not condition your enrollment in a health plan, eligibility for benefits or payment of claims on giving this authorization.

## Expiration and Revocation

**Expiration:** This authorization will expire upon termination of my health plan coverage, or upon settlement of claims incurred while covered, unless revoked or an earlier date or event is entered below:

- On \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ (Date)
- On occurrence of the following event(which must relate to the individual or to the purpose of the use and/or disclosure being authorized):

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**Right to Revoke:** I understand that I may revoke this authorization at any time by giving written notice of my revocation of First Administrators, Inc. at the address stated below. I understand that revocation of this authorization will *not* affect any action you took in reliance on this authorization before you received my written notice of revocation.

## Individual's Signature

**Specific Authorization for Release of Mental Health, Substance Abuse Treatment of Aids-Related Information:** I authorize the release and disclosure of any and all personal health information, including specifically mental health information, substance abuse (drug or alcohol), and AIDS-related information, if applicable, and all claims information to the individual named below as long as this appointment of Authorized Representative is in effect. I understand that I may inspect the mental health information disclosed.

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this personal representative appointment and authorization, and I understand that, by signing this form, I am confirming my authorization of the disclosure of my protected health information, as described in this form. If this authorization involves the disclosure of mental health information, I acknowledge receipt of a copy of the authorization.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*A spouse or parent of an individual 18 years or older may NOT sign on behalf of the individual without appointment through a legal process or by the individual submitting a personal representative appointment form.*

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name:

\_\_\_\_\_

Relationship to Individual:

\_\_\_\_\_

## Send completed and signed form to:

First Administrators, Inc.  
Compliance Dept.  
512 Main St., Suite 200  
PO Box 8150  
Rapid City, SD 57709

You may also **send via fax to 605-399-7950** or email to: [andee.creger@firstadministrators.com](mailto:andee.creger@firstadministrators.com)  
If you have questions about how to complete this form, please call (605) 399-7300.