



AUTHORIZATION TO RELEASE PERSONAL MEDICAL INFORMATION
(In order for this form to be valid, it must be fully completed.)

NAME OF MEMBER: _____

MEMBER ID #: _____ BIRTHDATE: _____ AGE: _____

Please complete and Mail or Fax to: Welborn Health Plans, ATTN: Enrollment
101 S.E. Third Street
Evansville, IN 47708
Fax: 716-541-6322

YOU ARE HEREBY AUTHORIZED TO RELEASE TO:

(Name of Person to Receive Information) _____

(Address and Fax Number) _____

THE INFORMATION SPECIFIED BELOW FOR THE FOLLOWING PURPOSE:

- To assist me with regard to claims and treatment
Other: _____

I understand that this authorization is subject to revocation by me (us) at any time except to the extent that action has been taken in reliance thereon; in which case, I understand that my revocation will not affect the uses and disclosures of such information, which have been before receipt of the revocation. I also understand that any information, which is released pursuant to this Authorization, may not longer be subject to the Privacy Rules which otherwise protect the privacy of such information. I also understand that this authorization will expire sixty (60) days from the date signed unless otherwise specified.

- (Date, event or condition on which authorization expires if other than 60 days)
Until I am no longer covered under Welborn Health Plans.

INFORMATION TO BE RELEASED

Signature of Member Date Signed

Street Address of Member Signature of Other Authorized Person*

City, State, Zip Relationship to Member

Phone Number of Member

Signature of Witness

* Authorization must be signed by the parent or legal guardian of any member under 18, the legal guardian of any member under guardianship, the personal representative of a deceased member, or if no personal representative the spouse of a deceased member, or if no spouse, any adult child of a deceased member (Chapter 8 of I.C. 16-4 - Acts of 1982). If member is under 18 and records are protected by Federal Law (42 CRF Part 2) regarding drug and alcohol abuse, authorization must be signed by both member and parent or legal guardian.