AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

ALL FIELDS MUST BE COMPLETED.

A separate form is required for each member on the policy or coverage, as needed. Please print legibly, or type, except where signature is needed.

To submit this authorization, please complete the information below, sign in the space provided and return to US Health and Life Insurance Company ("USHL"), 800 Tower Drive, Suite 300 Troy, MI 48098, or FAX: (586) 693-4321

SECTION A: MEMBER INFORMATION (*check whether request is for participant or dependent*)

Name (☐*Participant* ☐*Dependent*): ______________________________

Participant Identification #: ______________________________

Date of Birth: ________ / ________ / ________ Phone #: ______________________________
MM DD YYYY

Address: ______________________________

City: ______________________________ State: ____________ ZIP: ____________

SECTION B: AUTHORIZATION DETAILS

I AUTHORIZE US HEALTH AND LIFE INSURANCE COMPANY TO SHARE MY PERSONAL HEALTH INFORMATION:

List the amount or type of information you would like to share below. For example, you can say all of my health information, or list certain types of information you would like to share.

USHL MAY SHARE MY PERSONAL HEALTH INFORMATION WITH THE FOLLOWING PERSON OR ORGANIZATION:

Name of Person/Organization: ______________________________

Street Address: ______________________________

City, State, ZIP: ______________________________

Phone Number: ______________________________ Fax Number: ______________________________

USHL WILL SHARE MY PERSONAL HEALTH INFORMATION FOR THE FOLLOWING REASON:
For example, to discuss my health care benefits or at the request of the individual

BY SIGNING THIS FORM, I UNDERSTAND THAT:

- **Information regarding behavioral and mental health services, substance use disorder treatments, and communicable diseases such as sexually transmitted diseases and human immunodeficiency virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS related complex) may be shared if I initial here or if I list this type of information above __________.**
- If I authorize the release of substance use disorder treatment information, the recipient cannot re-disclose this information without my permission unless permitted under federal or state law.
- Other types of information shared under this authorization may be re-disclosed by the person or organization I identified above and may no longer be protected by federal or state law.
- I may change my mind and revoke (take back) this authorization at any time. To revoke this authorization, write to USHL and include a copy of the front of this form.
- Information that has already been shared based on this authorization cannot be taken back.
- I may request a copy of this signed authorization. If I have not previously revoked this authorization, it will expire on: (list a date, event or condition)

Date, Event or Condition (date you want this authorization to expire): _________ /____________ /__________
MM DD YYYY

Member/Representative Signature:____

Date: ________/_____________ /___________
MM DD YYYY

Representative Relationship (if applicable):___________________________________