Wabash Memorial Hospital Association
1501 North Water Street – Decatur, IL 62526
Customer Service (217) 429-5246 or 888-800-9161

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable protected health information as described below. I understand that this authorization is voluntary and not a condition of enrollment, eligibility for benefits or payment of claims. I understand that the released information may no longer be protected by federal privacy regulations if not released to a health plan or health care provider.

Section 1: MEMBER INFORMATION

Member Name_____**Phone (___)** _____
PLEASE PRINT

Date of Birth_____/_____/_____ **Social Security Number**_____-_____-_____
MM DD YYYY

Address_____
Street Address City State Zip Code

Section 2: WHO MAY RECEIVE INFORMATION

Release my protected health information to the following person(s) and or legal representative:

_____ _____ (____) -_____-_____
(Print full name) (Title or relationship to member) (Phone Number)

_____ _____ (____) -_____-_____
(Print full name) (Title or relationship to member) (Phone Number)

☐ Do not release my protected health information to anyone.

Section 3: WHAT INFORMATION THEY MAY RECEIVE

Specific description of information that may be released (including date(s). If you need more space, you may use the back of this form or include additional dated and initialed pages.

____ Dues / payment information
____ Copies of claims
____ Explanation of benefits, payments or denials
____ Medical records (***Wabash Clinic patients only***)
____ Other_____
Describe specific information

Section 4: HOW LONG CAN THEY RECEIVE INFORMATION

This authorization will expire on:

1) ☐ _____/_____/_____
MM DD YYYY

OR

2) ☐ On the occurrence of the following event: (e.g. termination of membership, death, divorce, etc.)_____

Section 5: SIGNATURE OF MEMBER

I may revoke this authorization at any time by notifying WMHA in writing. If I choose to revoke this authorization, it will have no effect on actions WMHA may have taken before they received my revocation.

_____ _____
Signature of member or member's legal representative Date