PARAMOUNT
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Member Name: ________________________________ Member Number: _________________________
(This should be the name and Paramount ID # of the person whose health information may be used or disclosed.)

Address: ____ Date of Birth: __________

(1) I authorize the use or disclosure of the above-named individual's health information as described below.
(2) The following individuals or organizations are authorized to make the disclosure:
Paramount
1901 Indian Wood Circle
Maumee, Ohio 43537
(3) The type and amount of information to be used or disclosed is as follows (check appropriate item(s); please include what specific "other" type of information may be disclosed, if you check the "Other" box:

❑ All of my personal and health information

❑ All claims and billing information only

❑ Other (please describe) ____

____

(4) This information may be disclosed to, and used by the following individuals or organizations:

Name(s) ____

Address ____
(Include all names and addresses of anyone to whom information may be disclosed.)

(5) This information is being disclosed for the following purpose(s):_________________________________

❑ Member Service Inquiries

❑ Other ____

(6) This authorization shall be in force and effect until the date of disenrollment from the plan, unless earlier revoked or as specified by the following: ____

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- I understand that the information in my health record may include information relating to sexually transmitted disease, tuberculosis (TB), hepatitis B, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
- I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above could be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
- I understand that I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan or eligibility for benefits.
- I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Paramount. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Signature of Member or Legal Representative ___________________________________ Date __________
(Signature of the member named at the top of this form, or his/her Legal Representative)

If signed by Legal Representative, relationship to member (attach proof) ______________________________

Please keep a copy of this form for yourself.