PARAMOUNT
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Member Name: _____ **Date of Birth**:_____

Member Number: _____
(This should be the name, member number and date of birth of the person whose health information may be used or disclosed.)

The following individuals or organizations are **authorized to make the disclosure**:
Paramount
1901 Indian Wood Circle
Maumee, Ohio 43537

Person/Physician/Entity authorized to RECEIVE the information (including address):

_____

_____

Date(s) of service/care for information requested:_____

Information to be disclosed (include dates where appropriate)
- ☐ All of my personal and health information (Medical records requests need to be submitted to your provider.)
- ☐ Claims and billing information only
- ☐ Other (please include what specific information may be disclosed)

_____

Purpose of Request (Complete Only for Third Party Requestor – Not Applicable for Member/ Member Representative Requests)
- ☐ Continuation of medical care ☐ Legal ☐ Member Service Inquiries
- ☐ Substantiation of payment of claims ☐ Personal use
- ☐ Other (specify) _____

Information should be delivered via (select one)
- ☐ I will inspect and review the record on-site ☐ Mail to address above
- ☐ Fax to_____ ☐ Paper or CD
- ☐ Email _____ (Note: Emailing is unsecure and could be intercepted by a third party.)
- ☐ Pick-up (provide name of individual picking up information): _____

1. 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.
2. 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.
3. I understand that treatment, payment for services rendered, enrollment in my health plan, or eligibility for benefits cannot be conditioned on the signing of this authorization, except in the instance of research-related treatment or when the provision of health care to me is solely for the purpose of creating protected health information for disclosure to a third party.
4. 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 the 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 as the law provides my insurer with the right to contest a claim under my policy.
5. In accordance with State law, unless otherwise revoked, for Ohio entities this authorization must be presented within one (1) year of the signature below; for Michigan entities this authorization must be presented within sixty (60) days of the signature below.
6. For Addiction Treatment and/or Behavioral Health Services Records: "This information has been disclosed to you from records protected by federal confidentiality rules. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client". OAC 5122-27-06.

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 instructions:_____

Signature of Patient or Legally Authorized Representative: _____Date: _____
Relationship to Patient: _____ Witness: _____

If you are the legally authorized representative of the patient, describe the scope of your authority (attach necessary proof)
- ☐ Custodial Parent/Legal Guardian ☐ Durable Power of Attorney for Health Care
- ☐ Legally Authorized Representative ☐ Personal Representative of the Estate
- ☐ Other (specify and attach proof) _____