CHP Consolidated Health Plans
A Berkshire Hathaway Company

AUTHORIZATION TO RELEASE INFORMATION

I, ___________________________________, hereby authorize Consolidated Health Plans (CHP) to release the following medical claim information pertaining to my health care coverage.

Specify information to be released: (check appropriate boxes)

☐ All
☐ Medical/ Diagnostic Information only
☐ Claims payment/submission information only

☐ Date of Service ___________________________________
☐ Medical Procedure ____________________(must specify)
☐ Claim/EOB #_________________________(must specify)

☐ OTHER:____

To the following person(s)

Name:	Relationship to you:
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

This form serves the dual purpose of being both general authorization for release of information and a specific authorization for the release of information protected by state and federal privacy and confidentiality laws. **THE INFORMATION TO BE RELEASED MAY CONTAIN INFORMATION PERTAINING TO MENTAL HEALTH, DRUG AND/OR ALCOHOL DIAGNOSES AND TREATMENT INFORMATION RELATING TO HIV TESTING OR AIDS RELATED DIAGNOSES AND TREATMENT.**

I understand that I may specifically request that only certain information be released and that the information released by this authorization will not be further relayed, by CHP, to any other person or entity without additional consent from me except to the extent allowed by law.

I further understand that CHP has no liability or responsibility in the dissemination of this information once it is released to an authorized person.

THIS AUTHORIZATION MAY BE WITHDRAWN BY ME AT ANY TIME PRIOR TO THE RELEASE OF THE ABOVE INFORMATION by contacting the Privacy and Security Officer at Consolidated Health Plans, 2077 Roosevelt Avenue, Springfield MA 01104 (413) 733-4540. If not withdrawn, this authorization will expire one (1) year from the date of signature.

I certify that I am of legal age to sign this authorization.

*Insured's Printed Name:____ Member ID:______________________

*Insured's Signature:____*Date:________________________

*Witness Signature:____ Date:________________________

(Must be signed by person **not** authorized for information release)

*Witness Printed Name:____

***Required**

Internal Use Only

Date Entered: ______________________ Entered By: ____________________________