SOLIS HEALTH PLANS

HIPAA Privacy Authorization Form

I, _____ authorize all medical service sources and health care providers to use and/or disclose the protected health information (PHI) described below to my Personal Representative(s) named as follows: _____

This authorization for release of PHI covers the period of healthcare (check one):

☐ From (Date) _____ to (Date), _____

☐ All past, present, and future periods.

I hereby authorize the release of PHI as follows (check one):

☐ I authorize the release of my complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse)

☐ I authorize the release of my complete health record with the exception of the following information:

- ☐ Mental health records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Other (please specify): _____

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct. This authorization to release information to my Personal Representative will automatically expire two (2) years following the termination of my enrollment with Solis Health Plans. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____

Signature of Beneficiary or Personal Representative | Date

_____ _____

Printed Name of Beneficiary or Personal Representative | Relationship to Beneficiary