HIPAA Compliant Authorization for Release of Medical Information

ADA No._____

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Print Name of insured/patient Date of Birth

I authorize any health plan, physician, healthcare professional, hospital, clinic, laboratory, holders of prescription information on me, including but not limited to, pharmacies, pharmacy benefits managers, and insurers, medical facility, or other healthcare professional that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record, prescription history, medications prescribed, eligibility, prescribing physician, pharmacy information, insurance coverage information and any other protected health information concerning me to Great-West. This includes information on the diagnosis of treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco.

By my signature below, l acknowledge that any agreements l have made to restrict my protected health information do not apply to this authorization and l instruct any physician, healthcare professional, hospital, clinic, medical facility, or other healthcare provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Great-West may administer claims and determine or fulfill responsibility for coverage and provision of benefits; administer coverage; and conduct other legally permissible activities that relate to any coverage l have or have applied for with Great-West.

This authorization shall remain in force for 12 months following the date of my signature below and a copy of this authorization is as valid as the original. l understand that l have the right to revoke this authorization in writing, at any time, by providing written notification to the entity identified above. I understand that a revocation is not effective to the extent that any of "My Providers" have already relied on this Authorization to disclose information about me or to the extent that Great-West has a legal right to contest a claim under an insurance policy or to contest the policy itself. l understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but will not be re-disclosed by Great-West except as authorized by me or as required by law.

I understand that "My Providers" may not refuse to provide treatment or payment for healthcare services if I refuse to sign this authorization, or otherwise condition my enrollment or eligibility for health benefits on my signing this authorization. l further understand that if l refuse to sign this authorization to release my complete medical record, Great-West may not be able to make any benefit payments. l understand that any authorized representative or l will receive a copy of this authorization upon request.

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Signature of Insured/Patient or Personal Representative Date

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Description of Personal Representative's Authority or Relationship to Patient

Please fax completed form to Great-West Financial: 303.737.4843