1639 North Alpine Road, Suite #401
Rockford, IL 61107
Website: secure.guidehealth.com

Standard Authorization to Use or Disclose Protected Health Information (PHI)

Section A: The individual for whom this authorization is being requested. Please complete the following:

Name _____ Group # _____ Identification\Subscriber # _____

Social Security Number _____ Date of Birth _____

Address _____ City _____ State _____ ZIP _____

Area Code & Telephone Number _____ E-mail address (if available) _____ Country _____

Section B: Who will provide this information?

Name: Guidehealth
Dept.: 1639 N. Alpine Road, Suite #401
Address: Rockford, IL

Section C: Who will receive this information?

Name _____
Phone _____
Relation _____

Section D: Describe the specific Protected Health Information to use or disclose, including date(s):

This authorization release will not expire unless a date is entered: _____

Please check all applicable options below for the type of information to be released:

☐ Eligibility, Benefit Information, Claim Status, Authorization Status, and updates

☐ Website Registration and Proxy additions

☐ Behavioral Health (eligibility, benefits, claims, and authorization)

☐ Other: (please be specific) _____

Section E: I understand that:

* This authorization will expire on the date listed in Section D above, or there will not be an expiration.
* This authorization is voluntary.
* Payment, enrollment, or eligibility for benefits for my health care will not be affected if I do not sign this form.
* I may revoke this authorization at any time by notifying in writing the company/individual listed in Section B from providing the PHI identified in this authorization, but if I do revoke this authorization, it will not have any effect on any actions Guidehealth took before they received the revocation.
* Information disclosed because of this authorization may no longer be protected by federal privacy laws and may be disclosed by the company or individual receiving the information.
* I should retain a copy of this authorization form for my records.

Section F: Signature

I hereby authorize the use or disclosure of the Protected Health Information as described in Section D for the individual listed in Section A.

Signature of individual or Individual's Personal Representative _____ Date: month/day/year _____

Section G: If Section F is signed by a Personal Representative, please complete the following:

Personal Representative's Name _____ Relationship to Individual _____

Personal Representative's Address _____ City _____ State _____ ZIP _____

Personal Representative's Area Code & Telephone Number _____ Personal Representative's E-mail address (if available) _____ Country _____

NOTE TO RECEIVING AGENCY/PERSON: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR, Part 2). 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 CFR, 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 the information to criminally investigate or prosecute any alcohol or drug abuse patient. State law regarding the confidentiality of mental health records also prohibits re-disclosure of this information without the specific consent of the person who consented to the disclosure.