UNITE HERE HEALTH
ALASKA

Authorization for Release of Protected Health Information

Fill out **completely** to prevent delay	**Submit form:** **Fax:** 702-733-2996 **Mail:** 1901 Las Vegas Blvd S., Ste 107 Las Vegas, NV 89104	**For help, call:** 844-427-8501

Check one: o I am the employee *(I get insurance coverage through my job)*
o I am a dependent *(I am in the employee's family and he/she provides my coverage)*

1: Employee Information

Last Name	First Name	Middle Initial	Date of Birth (mm/dd/yy)	SS # or Member ID #	Phone

Street	Apt #	City	State	Zip

2: Dependent Information

Full Name	Relationship to Employee	Date of Birth	Age	Phone

Street	Apt #	City	State	Zip

What is the purpose of this authorization? *(check one):*

o At my request o For a different purpose _____

I want UNITE HERE HEALTH to discuss and/or release my or my dependent's health information to the following person or organization:

Person/organization _____ Phone number _____

Relationship to me *(my sister, doctor, lawyer, etc.):* _____

I want UNITE HERE HEALTH to release the following information to the person named above *(check all that apply)*:

o ANY and ALL information o Explanation of Benefits o Eligibility o Enrollment o Appeal o Itemization of Lien

o Other _____

I want this authorization to expire *(check one):*

o Not until I revoke o On this date *(please specify):* _____

o When the following event occurs _____

If I don't check a box, this authorization will expire in one year.

I, _____ , authorize the use or disclosure of health information as described above. I have read and understand the contents of this form. I understand that UNITE HERE HEALTH cannot control information after it is released. I understand that this request may include reports, correspondence, test results, diagnosis, or medical procedures. I understand that I can revoke (cancel) this Authorization at any time by notifying UNITE HERE HEALTH's Privacy Officer in writing, but revoking will not affect information already released. If I revoke this Authorization, additional information will not be released, except where permitted or required by law. I am signing this form voluntarily. If I do not sign this Authorization, my ability to obtain treatment, payment, enrollment, or eligibility for benefits with UNITE HERE HEALTH does not change. ***By signing and dating this form, I am allowing UNITE HERE HEALTH to share my/my dependent's health information with the person or organization named above.***

3: REQUIRED Signature and Date

Signature of the person authorizing release of health information	Date

Print Name	Relationship to Employee	State	Zip

For Office Use Only	Date Received	Received By	Copy Mailed On	Copy Given to Patient On