Authorization to Release Information

I, _____, authorize HealthTrust to provide information to the following person(s): (If more than one person, please include additional information on the back of this form).

Information about the person you are authorizing to receive your information:

Last Name:	First Name:		Email:
Address:	City:	State:	Phone Number:
Recipient's Relationship to You (please check one): ☐ Spouse ☐ Parent ☐ Employer ☐ Child ☐ Personal Representative ☐ Other: _____			

Type of information you are authorizing to be released:

☐ Check this box if authorizing the release of any or all information which may include, but is not limited to, benefits and coverage, eligibility and enrollment, treatment, diagnosis, and financial information.
If not authorizing the release of any or all information, please provide a specific description of the information to be disclosed or the issue to be addressed (Please use the back of this form if more space is required):

By signing this form,

- I limit this authorization to only the dates of service specified above or only to the issue or problem described above. Furthermore, I acknowledge that this authorization will last until the termination of my membership with HealthTrust or until the resolution of the problem or issue described above, whichever is earlier.
- I understand that I can revoke this authorization at any time by writing to the Privacy Officer at HealthTrust, PO Box 617, Concord, NH 03302-0617.
- I know that my enrollment with HealthTrust is not conditioned on giving this authorization.
- I know that my treatment is not conditioned on this, except as it relates to research-related treatment for which authorization is required.
- I understand that the information used or disclosed pursuant to this authorization may be subject to the re-disclosure of information to other parties necessary for resolution or communication of this issue.

Please submit this form to HealthTrust Enrollee Services via mail at PO Box 617, Concord, NH 03302-0617, email at enrolleeservices@healthtrustnh.org, or fax at 603-226-2988.

Your Name (printed):	Your Date of Birth:	Your Contact Information (Address, Phone, Email):
Your Signature:	Date:	

If a legal representative signs on behalf of the individual, a copy of the legal representative's authority must be attached to this form, e.g., Health Care Power of Attorney, Executor/Administrator of an estate.

TO BE COMPLETED BY HEALTHTRUST WORKFORCE MEMBER	
Name of HealthTrust Workforce Member Receiving Form:	Date: