FAMILY CARE, LLC

Authorization to Disclose

Protected Health Information

Primary account holder information

Last name	First name		M.I.
Street address	City	State	ZIP
Email address (required)	Daytime phone ( )	SSN or ID number	

HIPAA authorization (to be completed by dependent)

My protected health information is individually identifiable health information, including demographic information collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse, and relates to: (i) my past, present, or future physical or mental health condition; (ii) the provision of the health care to me; or (iii) the past, present or future payment for the provision of health care to me.

Purpose of authorization: ☐ At my request ☐ Family member assisting with health care ☐ Other: _____

This authorization will remain in effect for the duration of the state expiration requirement (may vary from 24-48 months) based off of primary account holder's state of residency. In addition, I may revoke this authorization at any time by notifying the recipient.

Authorization of HIPAA disclosure (to be completed by dependent)

I understand that by granting this authorization, the person who obtains this information may disclose it to other individuals with or without my consent and in so doing, the information would no longer be protected under HIPAA. I understand that my authorizing the use and disclosure of my information is not a condition of enrollment in this health plan, eligibility for benefits or payment of claims.

Dependent's name (please print)	Date
Dependent's signature	Dependent's date of birth (mm/dd/yyyy)

Note: If the person signing above is a personal representative of the named individual, attach copy of document granting authority to the personal representative.


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