

Business Health Insurance Advocate

Use this form to authorize a non-owner employee or other person to discuss health insurance on behalf of the business.

I hereby authorize my health plan(s), my health insurance agent, navigator and their applicable business associates to disclose the following Private Health Information ("PHI") pertaining to me including enrollment, claims, payment and managed care information for the purpose of assisting me in my quest to obtain health insurance services and/or approval or payment for health insurance services.

Unless otherwise indicated, my authorization includes the release of the following:

(Strike through those you wish to exclude, if any.)

- Diagnosis and/or treatment of prior medical conditions of persons covered by the business plan
- Current medical information of persons covered by the business plan
- Business financial information
- Current or prior health insurance of the business or the individuals covered by the business plan

Identification of Business Authorizing Release

Name of Business:

Name of Person Authorizing release:

Title of Person Authorizing Release (Owner, Officer):

Date of Birth:

Address:

Identification of my Health Insurance Advocate

Name of Person Authorized to Receive Information:

Date of Birth:

Address:

Term of Health Advocate Authorization

Unless otherwise revoked, this authorization will commence on the date indicated below and will expire on the following date, event or circumstance: _____. If I fail to specify, this authorization will expire in twelve months.

Other Conditions

I understand that information used or disclosed based on this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.

I understand that I may revoke this authorization at any time by giving written notice of my revocation to health insurance advocate and any other parties affected.

I understand that revocation of this authorization will not affect any action my health insurance advocate or other parties who relied on this authorization before receiving my written notice of revocation.

Signature:

Date:

Witness: