

Authorization for the Use or Disclosure of Protected Health Information



430 West Soledad Avenue
Hagåtña, Guam 96910

As required by the Health Insurance Portability and Accountability Act of 1996 StayWell Insurance may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning to this office.

AUTHORIZATION SECTION

I, _____ hereby authorize the use and disclosure of any health information that pertains to me for the following purpose:

I authorize the following person(s) to **disclose** my health information:

I authorize the following person(s) to **receive** these disclosures of my health information:

I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to StayWell Insurance, 430 West Soledad Avenue, Hagåtña, Guam 96910. I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

I understand that this authorization will expire on _____
Expiration Date

I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

Signature Date

REVOCACTION SECTION

I hereby revoke this authorization.

Signature Date