# Authorization to Use or Disclose Protected Health Information (PHI)

FORM

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 our office.

**INFORMATION OF MEMBER OR INDIVIDUAL**

**Last** **First** **Middle**

**MEMBER NUMBER** **DATE OF BIRTH (Month/Day/Year)**

**ADDRESS** **CITY** **STATE** **ZIP**

**PHONE ( )** **ALT. PHONE ( )** **EMAIL ADDRESS (Optional)**

**I AUTHORIZE THE FOLLOWING TO DISCLOSE THE MEMBER/INDIVIDUAL'S PROTECTED HEALTH INFORMATION:**

(◯) **Island Home Insurance Co.** 520 Route 8 Maite, Guam 96910
(◯) **StayWell Guam, Inc.** 520 Route 8 Maite, Guam 96910
(◯) **StayWell Saipan, Inc.** 1st Floor RJ Commercial Bldg Chalan Monsignor Guerrero Road Dandan Saipan, MP 96950
(◯) **StayWell Manila, Inc. St. Luke's Medical Center - Global City** Unit 1135 Medical Arts Bldg., St. Luke's Medical Center, Bonifacio Global City, Taguig, Philippines
(◯) **StayWell Manila, Inc. St. Luke's Medical Center - Quezon City** Room 1104 - 1105 North Tower, 11th Floor Cathedral Heights Bldg. Complex St. Luke's Medical Center, 279 Rodriguez Sr. Ave. Quezon City, Philippines

**WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?**

1. Name Address
   Phone Date of Birth (Month/Day/Year)
   Drivers License No./Passport No./Guam ID No.
2. Name Address
   Phone Date of Birth (Month/Day/Year)
   Drivers License No./Passport No./Guam ID No.
3. Name Address
   Phone Date of Birth (Month/Day/Year)
   Drivers License No./Passport No./Guam ID No.
4. Name Address
   Phone Date of Birth (Month/Day/Year)
   Drivers License No./Passport No./Guam ID No.

**WHAT INFORMATION CAN BE DISCLOSED?** Complete the following by indicating those items that you want disclosed.

(◯) All Medical Information (◯) All Dental Information (◯) All Insurance Information

**EFFECTIVE TIME PERIOD:** This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional):
Month _____ Day _____ Year _____

**RIGHT TO REVOKE:** I understand that I can withdraw my permission at any time by submitting a written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

**SIGNATURE AUTHORIZATION:** I have read this form and agree to the uses and disclosures of the information as described. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

**SIGNATURE OF MEMBER/INDIVDUAL OR MEMBER/INDIVIDUAL'S LEGALLY AUTHORIZED REPRESENTATIVE** **DATE**