AUTHORIZATION FOR MEMBER INITIATED REQUEST FOR RELEASE OF PROTECTED HEALTH INFORMATION

Name of Employer: _____

Group Account Number *(Policy Number)*: _____

Primary Member *(Employee covered by the Health Plan)*: _____ , _____
(Last Name) (First Name)

Primary Member Identification Number: _____

Name of Person Granting Authorization: _____ , _____
(Leave blank if same as Primary Member) (Last Name) (First Name)

Your Relationship to Primary Member: _____
(self, spouse, dependent child, or designated personal representative)

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

For my purposes and at my request, I authorize Brown & Brown of New York Inc. dba Fitzharris & Company to disclose my protected health information to the following individual, organization, or class of persons (e.g., group individuals within the organization) (check all that apply):

☐ **My Employer/ Plan Sponsor:** The protected health information that may be used and disclosed to my Employer/Plan Sponsor is as follows (check all that apply):

Eligibility ☐
Explanation of Benefits ☐
Claims Status ☐
_____Other: (specify) ☐

☐ **My Broker:** (specify name) _____
The protected health information that may be used and disclosed to my Broker is as follows (check all that apply):

Eligibility ☐
Explanation of Benefits ☐
Claims Status ☐
_____Other: (specify) ☐

☐ **My Spouse:** (specify name) _____
The protected health information that may be used and disclosed to my Spouse is as follows (check all that apply):

Eligibility ☐
Explanation of Benefits ☐
Claims Status or Protected Health Information related to Claims Status
_____ Other: (specify) ☐

☐ **Other:** (specify name) _____
The protected health information that may be used and disclosed to this specified individual(s) is as follows (check all that apply):

Eligibility ☐
Explanation of Benefits ☐
Claims Status
_____Other: (specify) ☐

[If choosing "Other", describe in as much detail as possible the protected health information that you wish to be used or disclosed. For example, the information to be used or disclosed may relate to payment, enrollment, or claims. If so, you should include, if available, the types of claims, dates of service, or types of service.]

I understand that I may refuse to sign this authorization. I further understand that the above named health plan will not condition enrollment or eligibility for benefits on my signing this authorization.

I understand that I may revoke this authorization at any time by sending a written notification to the above named health plan at the address located below, and this revocation will be effective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective: (i) for information that the above named health plan already has used or disclosed, relying on this authorization or (ii) if the authorization was obtained as a condition for coverage in the above named health plan and, by law, the above named health plan has a right to contest the coverage. I may see and copy the information described on this form if I ask for it.

I understand that if my protected health information is to be received by individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by federal privacy regulations, my protected health information described above my be re-disclosed and no longer protected by federal privacy regulations.
This authorization expires at the earlier of: 1) 12 months from the date when it was signed or 2) when I am no longer an active member of the above named health plan.

_____ _____
Signature of Person Granting Authorization or Personal Representative Date

(Last)_____(First)_____
Printed Name

_____
Description of Personal Representative's Authority (if applicable)

You may contact me at the address below if you have questions concerning my responses in the Authorization:

_____
Street Address City State Zip

Phone: ( ) _____ Email: _____

Send your completed authorization or notice of revocation to the following address:

Attn: HIPAA Compliance Officer
Brown & Brown of New York Inc.
dba Fitzharris & Company
333 Earle Ovington Blvd Suite 215
Uniondale, NY 11553
Phone: (516) 777-4800

Or FAX to (516) 944-2953

NOTE: All authorizations granted by this document are in addition to any uses and disclosures of protected health information permitted or required under the Health Insurance Portability and Accountability Act of 1996 and its implementing privacy regulations.

This form is not to be used for obtaining records from providers for underwriting or risk rating.