Zion Health - HIPAA Authorization for Release of Health Information

I,_____, hereby authorize Zion Health and its affiliates, employees, and agents (collectively Zion Health), to receive my personal health information maintained by _____ (e.g., information relating to the diagnosis, treatment, claims payment, and healthcare services provided or to be provided to me and that identify my name, address, social security number, and/or member ID number), except the following information about me: _____ (describe information not to be disclosed, if any) for the purpose of helping me to resolve claims and health benefit coverage issues. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

This authorization is valid from the date of my/my representative's signature below and shall expire in 60 days.

I understand that I have a right to revoke this authorization by providing written notice to Zion Health. However, this authorization may not be revoked if Zion Health, its employees, or agents have acted on this authorization prior to receiving my written notice. I also understand that I have a right to a copy of this authorization.

I further understand that this authorization is voluntary, and I may refuse to sign this authorization. If I refuse to sign, I agree that it is my responsibility to reach out to my providers and provide Zion Health with the requested information needed to determine eligibility for sharing, enrollment, payment for, or sharing of services. I understand that without all necessary information, Zion Health may not be able to determine sharing or enrollment eligibility.

Name of Member: _____ Date of Birth: _____

Signature of Member: _____ Date: _____

If applicable, legal representatives sign below:

By signing this form, I represent that I am the legal representative of the member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the member's behalf with respect to this authorization form.

Name of Legal Representative: _____

Signature of Legal Representative: _____ Date: _____

Name of Witness: _____

Signature of Witness: _____ Date: _____