

**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION (PHI)
BY THE HEALTH PLAN**

EMPLOYER NAME _____

You MUST complete all the information in this Form for your Authorization to be Valid.

**MAIL OR FAX THE COMPLETED FORM TO THE BENEFIT ADMINISTRATOR
Noridian Benefit Plan Administrators, PO Box 2339, Fargo, ND 58108-2339 or Fax to 701-237-0626**

I authorize and instruct the Plan to use or disclosure of my health Protected Health Information (PHI) as described in this authorization. I understand the Plan may not condition my treatment, payment, enrollment or eligibility for benefits on whether or not I give the authorization listed in this form.

(1) **The Plan can release PHI to:** The Plan, its agents or subcontractors (Business Associates) is authorized to release the PHI described below to the following person, class of persons, or organization:

- My spouse My parents My Employer
- Other [Print Name or Position] _____

(2) **The information that may be used or released is:**

- Medical information held by the Plan from the following doctor, clinic, or hospital:
_____.
- Information held by the Plan concerning my eligibility, claims decisions and payments.
- Other. Please specify below:

_____.

(3) **Right to revoke:** I understand that I have the right to revoke this authorization at any time by notifying the Plan's Contact Person in writing at the address listed at the top of this Form. I understand that the revocation is only effective after it is received and logged by the Plan. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

(4) **Re-Release of Information:** I understand that after this information is released, federal law might not protect it and the recipient might re-release it. I also understand and agree to hold the Plan and any of its agents and subcontractors harmless if the information is re-released.

(5) **Copy:** I understand that the Plan will give me a copy of this authorization.

(6) **THIS AUTHORIZATION WILL EXPIRE ON THE DATE ON WHICH YOUR ELIGIBILITY UNDER THE PLAN TERMINATES UNLESS YOU SPECIFY ANOTHER DATE OR TERMINATION EVENT BELOW.**

Other: _____.

Your Signature _____ **Date** _____

Print Your Name _____ **Plan ID Number** _____