560 East 200 South · Salt Lake City, Utah 84102
800-765-7347 · 801-366-7555 · www.pehp.org

AUTHORIZATION TO RELEASE HEALTH INFORMATION

This form is not valid unless fully completed.

A photocopy of your government issued photo ID must be returned with this form for verification of signature.

Policy holder Information	
Last Name _____ First _____ Middle _____ Street Address _____ City _____ State _____ Zip _____ Phone (_____) _____ Date of Birth (mm/dd/yyyy) _____	
Subscriber ID # (listed on insurance card) _____	Current Date _____

I voluntarily authorize and request PEHP disclose information about the following people on the policy:

Member Last Name	First	Date of Birth (mm/dd/yyyy)
Member Last Name	First	Date of Birth (mm/dd/yyyy)
Member Last Name	First	Date of Birth (mm/dd/yyyy)
Member Last Name	First	Date of Birth (mm/dd/yyyy)
Member Last Name	First	Date of Birth (mm/dd/yyyy)

Information may be released to the following person/organization:

Name of person or organization	Date of Birth (mm/dd/yyyy)
Street Address, City, State, Zip	Phone ( )

Purpose of disclosure: check the box(es) below to indicate why you are requesting PEHP to release your information.

❒ For assistance with claims payment or processing. ❒ Enrollment information inquiry. ❒ Any reason.

Information to be released:

❒ I understand that Claims Payment Information includes the following:

Benefit information
Billing codes
Billed amount
Co-pay Amount
Allowed Amount
Deductible
Paid Amount
Coinsurance Amount
Claims status
Date of Service
Service Provider Name
Description of services
Amounts paid toward the yearly deductible or yearly out-of-pocket maximum.
Diagnosis information if a claim was denied.

Expires When: This authorization is good for 12 months from the date signed below.

❒ I have read both pages of this form and agree to the disclosure.

❒I have included a photocopy of my government-issued photo ID for verification of signature.

INDIVIDUAL authorizing disclosure

SIGN ▶

IF not signed by subject of disclosure, specify basis for authority to sign: "Guardian" or Other personal representative (explain)

Guardian sign here ▶

Print name

Date (mm/dd/yyyy)

This general/and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; and State law.

Form Approved 12/08/2017

Explanation of Authorization to Release Health Information Form

Laws and regulations require that PEHP obtain your written authorization to release health information to the person or organization your have indicated. You can provide this authorization by signing this form.

Once PEHP releases your health information according to this Authorization, PEHP cannot guarantee that this information will not be released to a third party or that your health information will be protected by federal and state law governing the use and disclosure of your individual health information.

Signing this from is voluntary; you have the right to revoke this authorization at any time, except to the extent that PEHP has already relied on it to release your health information. To revoke, send a written statement to PEHP, ATTN: Customer Service, 560 East 200 South, Salt Lake City, UT 84102. If you choose to revoke this authorization you must, also send a copy directly to the individual/ organization to whom you authorized PEHP to release your information to.