# Stetson University
# Authorization for Release of Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary and that I may refuse to sign this authorization, and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information.

Name: ______________________________________________________

ID Number: __________________________________________________

I authorize the Group Health Plan and Plan Sponsor to release the following information (Check all that applies).

| | |
|---|---|
| ______ Address, date of birth, membership status | ______ Claims |
| | ______ Premium Information |
| ______ Benefits | ______ Other (please specify) |

Group Health Plan and Plan Sponsor may release information to:

Name ______________________________________________________

Address____________________________________________________

Phone Number _______________________________________________

Purpose for this Release:

______ Request of Member or Personal Representative

______ Other (please specify)

**Right to Revoke**

This authorization is valid for one year after the date it is signed, unless an earlier expiration date is indicated here: ___________________.

_____________________________________ _______________________

Signature of Member Date

_____________________________________ _______________________

Signature of Parent or other Personal Representative Date

If this request is by a personal representative on behalf of the Member, complete the following:

Personal Representative's Name:

______________________________________________________

Relationship to Member:

______________________________________________________

**Note: You have a right to keep a copy of this notice after your sign it.**