



## Authorization for Release of Protected Health Information

### MEMBER/RETIREE SECTION

I  authorize the Health and Welfare Plan (the "Plan"), and its business associates, to disclose claims, payment, eligibility and other related health information about me to the following persons (select 1-2 persons if desired), at the request of such persons:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

I understand that this authorization will expire upon termination of my enrollment in the Plan, unless I revoke it sooner. I understand that I have the right to revoke it at any time, except to the extent that it has already been relied upon. I understand that if I decide to revoke this authorization, I must give notice of my decision in writing and send it to:

HIPAA Contact Person  
City of Detroit General Retiree Healthcare Trust  
700 Tower Drive, Suite 300  
Troy, MI. 48098

I understand that my health information that is disclosed pursuant to this authorization may be rediscovered by the persons I have identified above, and the Plan cannot prevent or protect such rediscoveries, AND I understand that I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).

**Signature of Member** \_\_\_\_\_ **Date Signed:** \_\_\_\_\_

-OR-  I do not want my Health Information released to anyone but myself.

**Signature of Member** \_\_\_\_\_ **Date Signed:** \_\_\_\_\_

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### SPOUSE SECTION

I, the spouse (Name, Please Print) \_\_\_\_\_, (Spouse's Social Security #) \_\_\_\_\_ of the above named member, have also read, understand, and authorize the Plan to disclose claims, payment, eligibility, and other related health information about me to the following persons (select 1-2 persons if desired) for the reasons and with the explanations listed above, at the request of such persons:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Signature of Spouse** \_\_\_\_\_ **Date Signed:** \_\_\_\_\_

-OR-  I do not want my Health Information released to anyone but myself.

**Signature of Spouse** \_\_\_\_\_ **Date Signed:** \_\_\_\_\_

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### DEPENDENT(S) OVER THE AGE OF 18 SECTION

I, the dependent child(ren) over the age of 18 (Name, Please Print) \_\_\_\_\_, (Social Security #) \_\_\_\_\_ have also read, understand, and authorize the Plan to disclose claims, payment, eligibility, and other related health information about me to the following persons (select 1-2 persons if desired) for the reasons and with the explanations listed above, at the request of such persons:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Signature of Dependent** \_\_\_\_\_ **Date Signed:** \_\_\_\_\_

OR-  I do not want my Health Information released to anyone but myself.

**Signature of Dependent** \_\_\_\_\_ **Date Signed:** \_\_\_\_\_

NOTE: If there is more than one dependent over the age of 18, please copy, complete and sign the appropriate number of additional Authorization Forms and return to the Benefit Office.