

**Member or Member's Dependent Authorization for Disclosure of Personal Health Information
Morgan White Administrators International, 3191 Coral Way, Suite 704, Miami, FL 33145 USA**

This authorization complies with the HIPAA Privacy Rule and permits health care providers and other covered entities to disclose personal health information.

1) I initiate this authorization for disclosure of my personal health information (defined in #2). I authorize Morgan-White Administrators International, its agents, and business associates (authorizee) to disclose my personal health information as described below. *Statement required by §164.508(c)(1)(ii).*

a) Please disclose my personal health information to (check as applicable):

My employer/plan sponsor (Please include name and address of employer/plan sponsor): *Statement required by §164.508(c)(1)(iii).*

Employer: _____
Attn: _____
Address: _____

Another person or entity (Please include name and address of person or entity to which the information is to be released): *Statement required by §164.508(c)(1)(iii).*

Name: _____
Address: _____

b) Describe the personal health information to be disclosed (check as applicable): *Statement required by §164.508(c)(1)(i).*

Please disclose any and all personal health information requested by the person or entity described above.

Please describe the personal health information to be disclosed:

Description: _____

c) Reason for the disclosure (optional): *Statement required by §164.508(c)(1)(iv).*

By my signature, I acknowledge that any prior agreements I have made to restrict my personal health information do not apply to the information released under this authorization.

2) I understand my personal health information may be used or disclosed as set forth by this authorization. Protected health information includes information created or received by Morgan-White Administrators International. Protected health information also includes but is not limited to: *Statement required by §164.508(c)(1)(i).*

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|-------------------------------------|---|
| • Hospital records | • Diagnosis |
| • Treatment records/office notes | • Prescriptions |
| • Alcohol or drug abuse treatment | • Test results |
| • Consultation reports | • Vocational Testing/counseling information |
| • Worker's compensation information | • Benefit information |

3) If you are the representative of the member or the member's dependent (including a member acting as a representative on a dependent's behalf) describe the scope of your authority to act on the member's or dependent's behalf; for example power of attorney, guardian, conservator: *Statement required by §164.508(c)(1)(vi).*

