

Authorization to Use or Disclose Specific Information

You must complete steps 1–6 for this authorization to be considered.

1	Member Name (Please Print):	Member DOB (mm/dd/yy):
	Member ID #:	Member Phone #:

I give my permission to Rocky Mountain Health Plans (RMHP), which includes plans underwritten by Rocky Mountain HMO and Rocky Mountain HealthCare Options, and/or Rocky Mountain Health Plans Home Health Agency (RMHP Home Health) to use/obtain or disclose this specific personal health information or records about me:

2	<input type="checkbox"/> All information relating to treatment, payment for services, and claims. OR
	<input type="checkbox"/> This specific information only:

The information may be shared with:

3	Name (Please Print):	Phone #:	Relationship to Member:
	Name (Please Print):	Phone #:	Relationship to Member:
	Name (Please Print):	Phone #:	Relationship to Member:
	Name (Please Print):	Phone #:	Relationship to Member:

The reason you may release the information described above is:

4	<input type="checkbox"/> Because I have requested OR
	<input type="checkbox"/> For this specific reason:

This authorization expires:

5	<input type="checkbox"/> When I am no longer an RMHP member OR
	<input type="checkbox"/> On this specific date or when this event occurs (e.g., August 5, 2010):

I understand that I may choose not to sign this form. Choosing not to sign will not affect my eligibility for or enrollment in a plan. Choosing not to sign will not affect my ability to receive health care treatment and will not prevent payment for health care benefits to which I may be entitled as a member of RMHP.

I understand that the person(s) named on this form could tell others about my personal health information that he or she receives from RMHP and/or RMHP Home Health. In that case, the laws that RMHP and/or RMHP Home Health follow to protect the information may no longer apply.

I may revoke this authorization at any time by notifying RMHP and/or RMHP Home Health in writing that I no longer give them permission to disclose information to the person(s) named on this form. I understand this revocation will not affect continued use or disclosure of my health information to the extent that RMHP or RMHP Home Health has already acted in reliance on this authorization.

6	Signature:	Date:
	Authority:	

(Your signature or a personal representative's; if a personal representative's signature, include a description of their authority to sign on your behalf. Documentation of authority may be required.)

For help in completing this form, please call Customer Service at 800-346-4643. Para asistencia en español llame al 800-346-4643.