# Authorization to Use or Disclose Protected Health Information

## Section A. General Instructions

**Please read this entire form before signing it and complete all the sections that apply to your decisions relating to the disclosure of protected health information ("PHI"). This Authorization will not be accepted and is not valid unless each section is fully completed. Please retain a copy for your records.**

By federal law, Solstice must have your written permission (an "authorization") to use or give out ("disclose") your PHI for any purpose that is not set out in our Notice of Privacy Practices. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as otherwise authorized by law.

If you want Solstice to give your PHI to someone other than you, then you (or your legally authorized representative) need to let Solstice know in writing. Use this form to advise Solstice of the person(s) you have chosen to have access to your PHI. Solstice will only disclose the PHI you want disclosed.

After you complete and sign this Authorization form, please sent it to: **Solstice, Privacy Office, PO Box 19199 Plantation, FL 33318.** If you have any questions or need additional assistance, please feel free to call us at 1-877-7602-2247, ext. 1714.

## Section B. Individual Who Is the Subject of the Use or Disclosure

Name: _____ Other Name(s) Used: _____
(First, Middle, Last)

Address: _____
City State Zip Code

Date of Birth: _____ Telephone #: _____ Email: _____
(Month/Day/Year)

Policy/Group #: _____ Social Security Number # (optional): _____

*Complete the following only if the person authorizing the use or disclosure is not the subject of the use or disclosure*

Name: _____ Relationship to Individual: _____

Representative's Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____ Email: _____

## Section C. Person(s) Authorized to Receive and Use Individual's PHI

Identify the individual(s) or organizations(s) to whom you are authorizing Solstice to disclose and let use the PHI described in Section D:

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone #: _____ Fax# : _____

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone #: _____ Fax# : _____

## Section D. Specific and Meaningful Description of PHI

Specifically and meaningfully describe the PHI you are authorizing Solstice to use/disclose to the person(s) identified in Section C and the reason you want the PHI used or disclosed:

_____

_____

## Section E. Expiration

This Authorization will expire automatically twenty-four (24) months after the date signed in Section G, unless you select a specific date or related event. Date/Event: _____

Please indicate whether this Authorization may be used to use or disclose the same type(s) of PHI described in Section D that may be created in the future, until the expiration date. Yes ☐ No ☐

**Section F. Acknowledgements and Signature of Individual or Individual's Personal Representative**

1. I understand that, by federal law, Solstice may not use or disclose PHI without authorization except as provided in Solstice's Notice of Privacy Practices. By signing this Authorization, I am giving permission for the use or disclosure of the PHI described in Section D to the person(s) identified in Section C. I hereby release Solstice and its employees from any and all liability that may arise from the release of information as I have directed.
2. I understand that I have the right to revoke this Authorization at any time by sending a written revocation to Solstice at the address listed in Section A. I understand that the revocation will not apply to information that has already been released in response to this Authorization.
3. I understand that information disclosed under this Authorization may be re-disclosed by the recipient and no longer protected by federal privacy laws.
4. I understand that this Authorization is voluntary and that I may refuse to sign this Authorization. I will not be denied treatment based on failure to sign this form, and my refusal to sign this form will not affect payment, enrollment, or eligibility for benefits.
5. I have had full opportunity to read and consider the contents of this Authorization, and I confirm that the contents are consistent with my direction to Solstice. I understand that, by signing this form, I am authorizing Solstice to use and/or disclose my PHI described in Section D to the person(s) identified in Section C.

Signature of Patient or Personal Representative:_____ Date:_____

Print Name:_____

**For Internal Use Only. Please complete, as applicable, consistent with Solstice policies and procedures.**

Verification of Identity (Individual) _____

Verification of Identity (Personal Representative) _____

Verification of Authority (Personal Representative) _____

Date Revocation Received (If Applicable)_____