Central Michigan University Benefits & Wellness Department

108 Rowe Hall, Mt. Pleasant, MI 48859
Phone: (989) 774-3661 Fax: (989) 774-1058

Authorization to Release Health Plan Records

I. Information about the records to be disclosed

By signing below, I authorize the staff of the Central Michigan University Benefits and Wellness Department ("CMU Benefits") to release my health plan records as described below:

My Name:_____
Last First Middle (Former or maiden if applicable)

Phone #:_____Date of Birth:_____CMU ID#_____

Recipient of Information. CMU Benefits may disclose my health plan records to the following individuals or organizations (include name and address):

_____
Name

_____
Street

_____
City State ZIP Code

_____
Phone #: Fax #:

Information to be released. CMU Benefits has health plan records that include information about your health plan coverage and your monthly contributions. These health plan records may also include information about treatment provided by health care providers, your physical or mental condition, medications, and amounts paid for your treatment and care. These records may include information relating to treatment for communicable diseases and infections, mental health, HIV and acquired immunodeficiency syndrome, drug or alcohol dependency, or genetic conditions. Unless you have indicated any restrictions below, you are permitting CMU Benefits to disclose all of the health plan records that it has about you to the recipient named above. **Restrictions.** If you do not want all health plan records released to the recipient, indicate the limitations you would like to impose (for example, release records relating only to certain doctors, treatments, or from a specific range of dates, etc.):

_____
_____
_____
_____

Specific purpose of the disclosure. If you would like to specify a purpose for the disclosure (such as "to resolve a claim for benefits" or "for purposes of litigation"), please list the purpose; otherwise, the purpose will simply be deemed to be upon your request: _____
_____
_____

Expiration date. Unless you indicate a different expiration date, this authorization will expire after one year. If you would like the authorization to be valid for a longer or shorter period of time, please state

a specific expiration date or event (for example, December 31, 2012, or an event that relates to you personally, such as "until my claim for benefits has been resolved"): _____

_____

_____

II. Important Information About Privacy Rights

I have read and understood the following statements about my privacy rights:

- I may revoke this authorization at any time prior to its expiration date by notifying CMU Benefits in writing, but the revocation will not have any affect on any actions CMU Benefits took in reliance on this authorization before it received my revocation.
- I may request a copy of this authorization.
- I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected under federal privacy laws
- CMU Benefits may not require me to sign this authorization in order for me to receive benefits under the Central Michigan University Flexible Benefits Plan. But if I do not sign this agreement, CMU Benefits will not be able to provide my records to the intended recipient.

III. Signature of Individual

_____ _____

Signature of individual (Or personal representative) | Date | Relationship if not the individual

If the authorization is being signed by a personal representative of the individual:

_____ _____

Personal Representative's Signature | Date

_____

Type/Print Name of Personal Representative

Description of Personal Representative's authority to act for the individual (attach supporting documents): _____

_____

For Benefits & Wellness Department use only

Completed by:_____ Date completed:_____ Delivery method: ☐ Faxed ☐ Mailed ☐ In Person