HIPAA Authorization Form
Assistance in Health Claims Administration

To: **Maine Municipal Employees Health Trust**
Subject: **Authorization to release health information for claims administration or resolution**

I, _____ ***(Member Name)***, authorize the Maine Municipal Employees Health Trust to release and discuss my personal health information for the purpose of ***(please check all that apply)***:

- ❒ Resolving questions about the payment/resolution of my health / dental / disability / vision claims **(*circle applicable plans*)**
- ❒ Resolving questions about my specific claim (please specify provider, date and/or diagnosis): _____
- ❒ Resolving questions about my eligibility
- ❒ Other (please specify): _____ _____

This health care information may be released to _____ ***(Authorized Person's Name)***.

This authorization expires on _____ **(*date or event – if applicable)***.

I, _____ ***(Member Name)***, understand that I may revoke this authorization at any time by providing the Maine Municipal Employees Health Trust with written notice that I am revoking this authorization.

I also understand that I may not revoke this authorization to the extent that _____ ***(Authorized Person's Name)*** and Maine Municipal Employees Health Trust have acted in reliance upon this authorization prior to the date I revoke this authorization.

I acknowledge that I have received a written copy of this authorization and I understand that I am not required to sign this authorization as a condition of eligibility in the health plan or payment of benefits.

I have read and understand all of the notices set forth above.

Member Signature: _____ Member SS# _____ Date:_____

Witness Signature: _____ **Witness Name**: _____ **Date:_____**
(please print)

If the Member listed above is not the covered Employee or Retiree, please complete the following information:

Employee Name _____ Employee SS# _____
Please print

**** Authorized Person*** means the individual to whom you grant permission to speak with Health Trust personnel regarding your claim(s) and/or coverage. An Authorized Person can be a parent, spouse, child, co-worker, or any other person who may help you with claim and/or coverage issues.

Individual Revocation of PHI Authorization

By completion of this form, I, _____ ***(Member Name)***,

am notifying _____***(Authorized Person's Name)*** **and** the Maine

Municipal Employees Health Trust that I am revoking my authorization dated _____ for

the Maine Municipal Employees Health Trust to release my health care information for the purpose of

_____

_____**(*describe purpose of authorization)***

I understand that I cannot revoke any action already taken by _____ ***(Authorized Person's Name)*** and the Maine Municipal Employees Health Trust in reliance upon my authorization prior to the date of this revocation.

Member Signature: _____ Member SS# _____ Date:_____

Witness Signature: **_____ Witness Name**: **_____ Date:_____**

If the Member listed above is not the covered Employee or Retiree, please complete the following information:

Employee Name _____ Employee SS# _____
Please print

**** Authorized Person*** means the individual to whom you grant permission to speak with Health Trust personnel regarding your claim(s) and/or coverage. An Authorized Person can be a parent, spouse, child, co-worker, or any other person who may help you with claim and/or coverage issues.