AlwaysCare Benefits, Inc.
Authorization for Release of Health Information

Patient Name: _____ **Date of Birth:** _____

Previous Name: _____ **S.S.#:** _____

Patient Mailing Address: _____

This will authorize AlwaysCare Benefits, Inc. ("AlwaysCare") to use and/or disclose the following protected health information as described below:

1. Specific description of my protected health information (including dates):

_____

2. Persons or Organizations receiving my protected health information:

_____

Initial

I understand that I may inspect or copy the protected health information which is subject to this Authorization. _____

I understand that this Authorization may be revoked in writing at any time, by delivery to AlwaysCare Benefits, subject to any action that has already been taken. _____

I understand that information used and/or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and, if so, may no longer be protected by federal or state privacy laws. _____

I understand that AlwaysCare shall not condition payment of benefits, enrollment in the Health plan, or eligibility for benefits under the health plan on my providing authorization for the requested use and/or disclosure and THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION. _____

I understand that AlwaysCare may receive direct or indirect renumeration from the Persons or organizations listed in item 2 above as a result of this authorization. _____

Date: _____

_____
Signature of patient or representative

_____
Relationship of representative to patient

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Reviewed by Lemle & Kelleher, LLP