

SelectHealth Advantage members:  
P.O. Box 30196  
Salt Lake City, UT 84130-0196  
Phone: 855-442-9900 (toll-free)  
Fax: 801-442-6580  
selecthealth.org/medicare

All other SelectHealth members:  
P.O. Box 30192  
Salt Lake City, UT 84130-0192  
Phone: 800-538-5038 (toll-free)  
Fax: 801-442-6580  
selecthealth.org



## Authorization to Release Health Information

**Form is not valid unless fully completed. Please return with a photocopy of the signer's government-issued photo ID.**

I understand the following information:

- Once SelectHealth® releases information according to this authorization, SelectHealth cannot guarantee that this information will not be re-released to a third party or that this information will be protected by federal and state law governing the use and disclosure of identifiable health information.
- This authorization will remain in effect until it expires or until I revoke it in writing.
- I may refuse to sign or may revoke this authorization at any time for any reason, unless SelectHealth has already made disclosures in reliance on this authorization.
- While SelectHealth does not condition the beginning, continuation, or quality of health insurance, care management, and other services it provides to me on my signing and not revoking this authorization, refusing to sign or revoking this authorization may limit SelectHealth's ability to provide such services to me.

**5. For SelectHealth Advantage® members:** This signed authorization form does not give the individual named below the authority to initiate an appeal, grievance or prior authorization on my behalf. I must complete an additional form—Appointment of Representation—to grant that authorization.

In understanding the above, I agree to let SelectHealth share my information as described in this form. If I have questions, I can call SelectHealth. SelectHealth Advantage members call: **855-442-9900** (toll-free). All other SelectHealth members call: **800-538-5038** (toll-free). TTY users may call 711.

### Member Information

First Name \_\_\_\_\_ Last Name \_\_\_\_\_  
Member ID (on ID Card) \_\_\_\_\_ Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Ph# (\_\_\_\_) \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YYYY

SelectHealth may share information about the SelectHealth member named above (check one):

For one year from the signature date  For the length of the policy  Until this date \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YYYY

**NOTE:** If expiration date is not indicated, authorization remains active for one year from the signature date.

The member's information may be shared with the following person or organization (only one person or organization per form):

Name of person or organization \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
(if person) MM DD YYYY

Relationship to Member \_\_\_\_\_

Street Address \_\_\_\_\_ Ph# (\_\_\_\_) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Type of Information to be share (check the box(es) below to choose which information you would like shared).

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Enrollment                   | <input type="checkbox"/> Existing appeal information | <input type="checkbox"/> All of the the above |
| <input type="checkbox"/> Contact                      | <input type="checkbox"/> Care management             | <input type="checkbox"/> Other _____          |
| <input type="checkbox"/> Existing prior authorization | <input type="checkbox"/> Claims payment              | _____   |

### SIGNATURE

Signature of member or legal representative \_\_\_\_\_ Description of legal representative's authority \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_  I have included a photocopy of the signer's government-issued photo ID.  
MM DD YYYY

### SELECTHEALTH USE ONLY: ATTENTION MEMBER SERVICES

Password \_\_\_\_\_

Security Question \_\_\_\_\_

Security Question Answer \_\_\_\_\_