



Authorization to Release Health Information

I, *(please print name)* _____, hereby authorize and direct Capital District Physicians' Health Plan, Inc., Capital District Physicians' Healthcare Network, Inc. or CDPHP Universal Benefits, Inc. (collectively referred to as "CDPHP") to furnish and release the following information regarding my coverage (or the beneficiary's coverage, if completed by someone other than the beneficiary) *(please describe the specific information to be released or indicate "all" if you want another person to deal with CDPHP for all of your questions and issues):*

To *(please print name/address):* _____

I am requesting that the information noted above be released for the following purpose(s) *(please describe the purpose(s) for the release):*

(If you do not wish to state a specific purpose, please state "at the request of the individual".)

Check only one box below for the period of time the authorization is to be in effect:

- Duration of CDPHP enrollment From _____ to _____

I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect CDPHP's payment for services or my eligibility for CDPHP benefits. I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the federal privacy rules of the Health Insurance Portability and Accountability Act of 1996. I understand that I have the right to revoke this authorization at any time except to the extent that CDPHP and/or other professionals or entities have already acted in reliance on it. I understand that in order to revoke this authorization my revocation must be submitted in writing to: Privacy Compliance Administrator, Corporate Compliance, Capital District Physicians' Health Plan, Inc., 500 Patroon Creek Blvd., Albany, New York 12206-1057. In the case of a minor dependent, this authorization will terminate upon the first of the following to occur: written revocation by me, the date/event noted above or when the named minor dependent reaches the age of eighteen (18) years.

I authorize release of the information specified above in my capacity as *(select one)*:
 Self Guardian *(please attach legal documentation)* Parent
 Power of Attorney *(please attach power of attorney documentation)*

Signature

Date

Print Name

Beneficiary's CDPHP ID#

Witness Signature

Date

Print Witness Name

This authorization must be filled out completely in order for it to be valid.