CRESCENT
HEALTH SOLUTIONS

Member/Dependent Authorization to Disclose PHI

You may give Crescent Health Solutions, Inc. written authorization to disclose your Protected Health Information (PHI) to anyone you designate and for any purpose. If you wish to authorize a person or entity to receive your PHI, please complete the information below.

Completion of this form will not change the way Crescent Health Solutions communicates with members or dependents*; Explanation of Benefits (EOB) statements, for example, will still be sent to the member.*

MEMBER/DEPENDENT NAME	MEMBER/DEPENDENT DATE OF BIRTH (month/day/year)
MEMBER/DEPENDENT ADDRESS	MEMBER ID NUMBER

At my request, I authorize Crescent Health Solutions to disclose my PHI to (enter name and relationship of person/entity who will receive your PHI):

_____ _____
NAME RELATIONSHIP TO MEMBER/DEPENDENT

I authorize Crescent Health Solutions to disclose the following PHI to the person/entity listed above:

- ☐ Any Information Requested
- ☐ Enrollment Information
- ☐ Premium Payment (COBRA)
- ☐ All Claims Information
- ☐ Web Access to Claims Data
- ☐ Benefit Information
- ☐ Explanation of Benefits (EOB) Information
- ☐ Case management information
- ☐ Disease management
- ☐ Pharmacy Benefit information

- ☐ All services from a specific health care provider (list providers name)_____
- ☐ Other (please list specific PHI):_____

I would like this authorization to expire on: _____ **OR** ☐ When my coverage expires.
EXPIRATION

If no expiration date is provided, this authorization will expire twelve (12) months from the date of receipt by Crescent Health Solutions.

I understand that I may revoke this authorization at any time by giving Crescent Health Solutions written notice to the address at the bottom of this form. I also understand that revocation will not affect any action that Crescent took in reliance upon this authorization before receiving my written notice of revocation.

I also understand that if the persons or entities I authorize to receive my PHI are not health plans, covered health care providers, or health care clearinghouses subject to the Health Insurance Portability and Accountability Act (HIPAA) or other federal health information privacy laws, they may further disclose my PHI and it may no longer be protected by HIPAA or federal health information privacy laws.

I also release and discharge Crescent Health Solutions from any and all liability, cost, and claims of whatsoever kind and nature arising from the release of this information.

Signature_____ Date _____

If signed by a personal representative:
Print your full name: _____
Describe your authority to act for the member (e.g., power of attorney, administration, parent of minor child, executor of estate, etc.):

_____

COMPLETE THIS AUTHORIZATION AND FAX TO TPA SERVICES AT 828-670-9155.