

Orion Health Insurance Pool, Inc. (ORION)
Authorization Form for Release of Protected Health Information (PHI)

I, _____, hereby authorize the use or disclosure of the health information as described in this authorization.

1. Specific person/organization/or class of persons authorized to **provide** the information:

 2. Specific person/organization/or class of persons authorized to **receive** and use the information: *(insert name, title, address fax, phone and e-mail if possible)*

 3. Specific **description of the information to be used or disclosed**. *(Include names of individuals to whom the information pertains such as a minor child, description of information and dates, as appropriate):*

 4. **Purpose of the request:** *(Check one)*
 At the request of the individual signing this form.
 Other: _____
 5. **Right to Revoke:** I understand that this authorization is voluntary and that I have the right to revoke this authorization at any time by notifying the Privacy Officer (in writing) at the address noted at the bottom of this form. I understand that such a revocation is only effective after it is received and logged by the Privacy Officer. I understand that any use or disclosure made prior to the revocation of this authorization will not be affected by a revocation.
 6. **I understand that after this information is disclosed, Federal law might not protect it and the recipient might disclose it again.**
 7. I understand that I am entitled to receive a copy of this authorization and the information described on this form if I ask for it.
 8. I understand that this authorization will expire as indicated below:
 One year from the date of this authorization.
 On the following date: _____, 20__.
 9. The Plan will not condition treatment, payment, enrollment or eligibility for benefits on receipt of an authorization.
 10. If this authorization is **for marketing purposes**, this Plan is not receiving financial remuneration (payment) from the third party whose service or item is being marketed. If the authorization is **for the sale of protected health information**, the disclosure will not result in remuneration (payment) to the Plan.
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Signature of Individual

Date

or

Signature of Personal Representative

Date

If a Personal Representative executes this form, that Representative warrants that he or she has authority to sign the authorization form on the basis of: a signed Personal Representative Form; or Other _____

This authorization reflects the requirements of 45 CFR § 164.508 (8-14-02) and updated for HIPAA Omnibus (9-23-13).

Once completed, please return this form to the:
Orion Health Insurance Pool, Inc. (ORION)
ATTN: Privacy Officer
333 East Osborn, Suite 300 Phoenix, AZ 85012
Telephone: 1-800-718-8328