CENTRAL REGION SCHOOL INSURANCE GROUP
4101 Tully Road, Suite 501
Modesto, CA 95356
(209) 579-7535

INDIVIDUAL AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

This form authorizes the disclosure of your private health records and related information to Central Region School Insurance Group (CRSIG) and/or your School District, which can then disclose the information to individuals or entities that you designate below in order to resolve your questions or issues.

Section 1:
I hereby request and authorize the use or disclosure of my (or my child's) "protected health information" (PHI) as described below.

Patient Name	Patient Date of Birth	Patient SS# or Plan ID#
Patient Address	City, State & Zip Code	Patient Phone #
Subscriber/Member name (if different from patient)		Subscriber/Member ID#

Section 2:
The individual(s) or entity(ies) authorized to disclose the protected health information is/are: *[List group health plan, and any hospitals or medical providers involved in the claim you are seeking help to resolve.]*

_____ Doctor:_____ _____ Hospital:_____

_____ Lab:_____ _____ Carrier:_____

_____ Other:_____

Section 3:
The individual(s) or entity(ies) authorized to receive the protected health information is/are:
1) CRSIG, Attn: Angela Jacobson, 4101 Tully Road, Suite 501, Modesto, CA 95356
phone (209)579-7535, fax (209)579-7530
2) School District:_____

Section 4:
The types of protected health information which may be disclosed include: *[Check all that apply, and specify "from (date) to (date)" if you wish to limit by dates.]*

_____ Claims records, claims status, and patient management records, pertaining to (specify injury or illness)
_____ From (date)_____ to (date)_____
_____ Medical records pertaining to the above specified injury or illness, during the same dates specified above
_____ Other:_____
_____ Unless the claim to be resolved involves the following, do not disclose protected health information on chronic diseases, behavioral health conditions, including alcohol or substance abuse, communicable diseases, including HIV/AIDS, and/or genetic marker information.

Section 5:
The purpose for which the disclosure may be made is: *[Check only one.]*

_____ At the request of the individual.
_____To allow the plan, broker (a "Business Associate") or plan sponsor to assist the individual in getting a claim resolved and paid.
_____ Other:

Section 6:
This authorization shall be in force and effect until: *[Check one.]*

_____ *[Specify Date]:*_____
_____ The claims I have requested assistance in resolving are completely resolved and/or paid.

If neither of *above items* are *checked* or *completed, this Authorization will expire* as of *one year from the date this Authorization is signed.*

You have the right to revoke this Authorization at any time, by sending written notice to the individual or entity you listed above in Section 2. However, if you revoke this Authorization after protected health information has been disclosed, the disclosing entity will not be able to take back the information previously disclosed.

Section 7:
This Authorization and request for disclosure is voluntary. I understand that my eligibility for benefits and payment for services covered by this group health plan will not be affected if I do not sign this form. However, if I do not complete and sign this form, providers (such as hospitals and doctors) and the group health plan cannot release protected health information to the party(ies) I have listed in Section 3.

I hereby request and authorize the use or disclosure of my (or my child's) "protected health information" (PHI) as described above. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

_____ _____
Signature of health plan member (or parent or legal representative, if applicable) Date

_____ _____
Print name of plan member or legal representative* Relationship to plan member

*If this Authorization is being signed by the legal representative of the individual to whom the protected health information pertains, you must furnish a copy of the power of attorney or other relevant document designating you as the legal representative.

RETURN THE COMPLETED FORM TO:

CRSIG
Attn: Angela Jacobson
4101 Tully Road, Suite 501
Modesto, CA 95356

SCHOOL DISTRICT:
Attn:_____
_____
_____

OR FAX COMPLETED FORM TO: (209) 579-7530 _____

PLEASE CALL JUST BEFORE FAXING THIS FORM IF YOU WANT US TO PICK UP YOUR FAX IMMEDIATELY, TO PROTECT THE CONFIDENTIALITY OF THIS INFORMATION. THE PHONE NUMBER TO CALL IS (209) 579-7535 AT CRSIG OR _____ AT THE SCHOOL DISTRICT.

THE PERSON SIGNING THIS FORM SHOULD RETAIN A COPY OF IT, OR THE HUMAN RESOURCES DEPARTMENT SHOULD MAKE A COPY IF THE INDIVIDUAL DOES NOT ALREADY HAVE ONE.