



**ASSOCIATION & SOCIETY  
INSURANCE CORPORATION**

Corporate Office: 2301 Research Blvd. Ste.300 Rockville, MD 20850  
Mailing Address: P.O. Box 2107, Rockville, MD 20847  
301-816-0045 ♦ 1-800-638 -2610 ♦ fax 1-800-310-5514

## Authorization for Release of Protected Health Information

You may authorize **ASI Corporation** in writing to share your health information with a third party such as a family member, friend, employer, lawyer, individual broker or unrelated party. By completing and submitting this authorization, you allow another person or organization, designated by you, to have access to your health information. This authorization will be effective once it is entered into our systems, which is typically 5 business days from receipt.

**Please print neatly to ensure correct processing and to prevent any delays in service.**

### 1. Member Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Member's Address: \_\_\_\_\_  
\_\_\_\_\_

Member's Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Member's Date of Birth: \_\_\_\_\_

Member's Certificate #: \_\_\_\_\_

### 2. At my request, I authorize my protected health information to be disclosed to:

1. First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Relationship to Member/Company Name: \_\_\_\_\_

2. First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Relationship to Member/Company Name: \_\_\_\_\_

3. First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Relationship to Member/Company Name: \_\_\_\_\_

**3. I authorize the following disclosure of my protected health information (PHI) to the person/organization listed above. Check all topics that apply:**

- |  |  |
|--|--|
| <input type="checkbox"/> All of my information               | <input type="checkbox"/> Claims and EOBs               |
| <input type="checkbox"/> Enrollment and Benefits information | <input type="checkbox"/> Premium Payment               |
| <input type="checkbox"/> Any documents related to an appeal  | <input type="checkbox"/> Mental Health/Substance Abuse |

**To further limit the information being shared, please be specific as possible when selecting the options below:**

All Services for a specific date (provide dates of service): From: \_\_\_\_\_ To: \_\_\_\_\_

All Services from a specific health care provider (list Provider's name):

\_\_\_\_\_  
\_\_\_\_\_

Other (please list specific PHI):

\_\_\_\_\_  
\_\_\_\_\_

**4. Expiration**

I would like this authorization to expire:

on \_\_\_\_\_ (Check this option if you want the authorization to expire  
Date in less than one year.)

after a specific event has occurred (e.g. after heart surgery or at the end of a pregnancy):

\_\_\_\_\_  
\_\_\_\_\_

*This authorization will expire one year from the date signed unless you select one of the options above..*

**5. Right to Revoke (cancel)**

I understand that I may revoke this authorization at any time by giving written notice to **ASI Corporation at P.O. Box 2107, Rockville, MD 20847-2107**. Revoking this authorization will not affect any action that **ASI Corporation**, or others named or unnamed herein, took before **ASI Corporation** received my written notice of revocation.

The Notice of Privacy Practices includes information about the opportunity to revoke an authorization, and the and the exceptions to this right. You may refer to the Notice of Privacy Practices for this and all other information pertaining to your Privacy rights.

**6. Signature**

I, \_\_\_\_\_ hereby authorize the use and/or disclosure of my identifiable health information as described above.

I understand that:

- this designation is voluntary and being made at the request of the individual; and
- the released information may no longer be protected by federal privacy laws and maybe redisclosed by the individual or organization authorized to receive the information; and
- this authorization will not be used for medical underwriting; therefore, my treatment, payment, enrollment or eligibility for benefits will not be conditioned on my signing this authorization.

I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to **ASI Corporation**. I understand by signing this form, I am giving my authorization to **ASI Corporation** to use and/or disclose the protected health information described above to the persons and/or organizations named in this form.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If the person signing this authorization is not the member\*, please provide your full name and describe the relationship to the member.

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**Print Your Full Name**

\_\_\_ Personal Representative    \_\_\_ Power of Attorney    \_\_\_ Legal Guardian    \_\_\_ Other \_\_\_\_\_  
**Please Describe**

*\*The proper documentation must be on file before the authorization can be processed.*

**7. Please Mail or fax this authorization to:**

**ASI Corporation  
P.O. Box 2107  
Rockville, MD 20847-2107**

**Fax: 1-800-311-3124**

Please keep a copy of this authorization.  
We will provide you with a signed copy of this authorization on request.

Any mental health or substance abuse information, which has been disclosed from medical or other health care records, may be protected by federal and/or state law. If the records are so protected, Federal Regulation (42 CFR Part 2) prohibits the recipient of the information from making any further disclosure of this information unless such disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.