# Health Care Advocate

I hereby authorize my health plan(s), my healthcare providers and their applicable business associates to disclose the following Private Health Information (“PHI”) pertaining to me including enrollment, claims, payment and managed care information for the purpose of assisting me in my quest to obtain health care services and/or approval or payment for health care services.

Unless otherwise indicated, my authorization includes the release of the following: *(Please strike through those you wish to exclude, if any.)*  
• Diagnosis and/or treatment for alcoholism and/or drug abuse or dependency  
• Diagnosis and/or treatment regarding mental health issues  
• HIV antibody test results and/or diagnosis and treatment  
• Genetic test results and/or related treatment  
Identification of person authorizing release.

**Identification of my Health Care Advocate**

Name:

SSN:

Date of Birth:

Address:

**Term of Health Advocate Authorization**

Unless otherwise revoked, this authorization will commence on the date indicated below and will expire on the following date, event or circumstance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.  If I fail to specify, this authorization will expire in twelve months.

## Other Conditions

I understand that information used or disclosed based on this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.

I understand that I may revoke this authorization at any time by giving written notice of my revocation to health advocate and any other parties affected.

I understand that revocation of this authorization will not affect any action my health advocate or other parties took in reliance on this authorization before it received my written notice of revocation.

Signature: Date:

Witness: