STATE EMPLOYEES' INSURANCE BOARD

PO Box 304900 • Montgomery, AL 36130-4900
201 South Union Street, Suite 200 • Montgomery, AL 36104
Phone: 334-263-8341 or 1-866-836-9737 • Fax: 334-263-8541
www.alseib.org

Faye Nelson
Chair

William L. Ashmore
CEO

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PLEASE RETAIN A COPY OF THIS AUTHORIZATION FOR YOUR RECORDS AFTER YOU SIGN IT.			
Member's Name:	Date of Birth: (mm/dd/yyyy)		Contract # (As it appears on your card)
Address:			
City:	State:	Zip Code:	Telephone Number:

I _____authorize the disclosure of my Protected Health Information to the following Individual:

Name:		Telephone Number:
Address:		
City:	State:	Zip Code:

Check the applicable plan or policy:

SEHIP Medical	☐ Medicare Advantage	☐ Supplemental Plan
Optional Plan	☐ Premium Cash Option	☐ BCBS Dental Plan
Southland Dental Plan	☐ Southland Cancer Policy	☐ Southland Vision Policy

The type of information to be disclosed:

☐ All of my Protected Health Information ☐ Other (please specify) _____

Purpose of this disclosure of my Protected Health Information (select one)

☐ At my request ☐ Other (please specify) _____

Date of Expiration of this Authorization (select one)
If no expiration date is indicated, this authorization will expire in 90 days from the date of this authorization.

☐ Until coverage under my health plan terminates or ☐ Expiration Date _____

By signing this authorization, I understand that my Protected Health Information described herein may be re-disclosed by the person(s) I have authorized to receive and use my Protected Health Information and that my Protected Health Information described herein may no longer be protected by federal privacy laws.

I understand that I may revoke this authorization at any time by giving written notice of my revocation to the address listed above. I understand that revocation of this authorization will not affect any action taken in reliance on this authorization before you receive my written notice of revocation.

Signature: _____ Date: _____

Printed Name: _____ Relationship to Member: _____
If signed as a Personal Representative, you must provide documentation of your authority to act as the Personal Representative of the individual who is the subject of the Protected Health Information described in this authorization (e.g., Parent, Power of Attorney, Guardianship, or Conservatorship).