All Atlantic Benefits

HIPAA INDIVIDUAL Authorization Form

Authorization For Release Of Information

Insurance Company:____

Provider:____

Member: ______________________________

Patient: ______________________________

ID #: ______________________________

Address: ______________________________

City, State & Zip: ______________________________

I hereby authorize the use and or disclosure of my health information and appoint All Atlantic Benefits, 3440 Hollywood Boulevard, Suite 465, Hollywood, FL 33021, and their employees as my representative as it relates to my health care coverage information. I understand that this authorization is voluntary.

Printed Name of All Atlantic Benefits Representative:

____

I authorize the above named representative of All Atlantic Benefits to make any request or notice of information pertaining to my health care coverage information including but not limited to:

- ○ Demographic information (e.g. name, address, age, gender)
- ○ Health Care coverage information
- ○ Past, Present and Future claims information

I understand that this authorization will expire on ______/______/______
(MM / DD / YYYY)

<u>OR</u>

Will be valid until Health Care coverage ends.

____ ____________________
Signature of Member or Dependent Date
(*Form MUST be completed before signing)*

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION