Health Advantage

An Independent Licensee of the Blue Cross and Blue Shield Association

# AUTHORIZATION FOR RELEASE OF INFORMATION & ASSIGNMENT OF AUTHORIZED REPRESENTATIVE

I, ____________________________ hereby authorize Health Advantage, their directors, officers, employees and agents, to disclose to _________________ all information or data in any form, whether oral, written, electronic, video, or computer data, which relates to or references ____________________________. The information which I hereby authorize to be disclosed shall include but shall not be limited to any information showing, relating to or arising from: (i) any benefit claims, or the processing, payment, denial or appeal of such claims; or (ii) the services provided by Health Advantage; or (iii) any medical records, notes or documents of any kind; or (iv) any communications, notes or statements of any person or entity regarding or relating to any of the foregoing. Unless listed as a restriction, the authorized representative will be allowed to make PCP changes. ***Other data changes will only be accepted by the policy holder and may require being made through the employer.*** This authorization shall remain valid and effective until after such time as I have delivered written notice to either the person at Health Advantage who obtained this authorization from me or to an office of Health Advantage that I intend to revoke the authorization. I understand and agree that this authorization shall apply to all information disclosed by Health Advantage prior to the time that my written notice of revocation is actually received by either the person who obtained it from me or an officer of Health Advantage, as referenced above. I hereby warrant and represent to Health Advantage and to any person relying upon this consent that I am fully authorized to consent on behalf of _____________________________ in my capacity either as parent or legal guardian (or both) of ______________________________, and further warrant and represent that there is no other person or entity authorized to act exclusively in this respect, nor any legal or other restraint or prohibition against my acting in such capacity.

**List limitations/restrictions here**_________________________________________________________

_____________________________________________________________________________

________________________________________ ___________________________

Signature of Parent or Guardian (circle as applicable) Date Signed

________________________________________ ___________________________

Member Name Health Advantage I.D.#

The request must be mailed or faxed to Health Advantage at
Attn: Customer Service
P.O Box 8069
Little Rock, AR 72203
Fax number: 501-212-8518