



### Authorization to Disclose Protected Health Information (PHI)

I hereby give consent to Health Republic Insurance of New York to use and disclose my protected health information (PHI) for the purposes of payment of my claims (as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA)) to the following person:

Name of person consent given to:	
Relationship to Member:	

**Allow Health Republic Insurance of New York to release:**

☐ Limited Information

If Limited is checked, please select which information to release:

☐ Information about eligibility

☐ Information about claims submitted to Health Republic Insurance of New York

☐ Information about benefits and services

☐ Information about premium payments

☐ Other (please specify): \_\_\_\_\_

☐ Any Information

☐ ALL health-care related Information

This consent will terminate ON: Specify date or indicate no termination\*  
date \_\_\_\_\_ (mm/dd/yyyy)

If no termination date indicated, you must notify us to make any changes and/or discontinue the release of information.

**I authorize Health Republic Insurance of New York to disclose my personal health information listed to the person named above. I understand that my personal health information may be re-disclosed by the person listed above and may no longer be protected by law. I also understand that at any time, I have the right to revoke this consent provided that I do so in writing to Health Republic Insurance of New York.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date (mm/dd/yyyy)



Please print member's name and address (Street Address, City, State and Zip Code)

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☐ Check here if you are signing as a personal representative and complete information below. Please attach the appropriate documentation (*i.e.* Power of Attorney). This only applies if someone other than the member signed above.

Print the Personal Representative's address (Street Address, City, State and Zip Code)

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Telephone number for Personal Representative: \_\_\_\_\_

Relationship to Member: \_\_\_\_\_

**All information provided will be validated by HRINY**

***Note: To remove or change a disclosure authorization on file please contact Member Services at 888 990 5702 Monday through Friday 8:30 AM-5:30 PM***

**Please submit this form by fax or mail**

**Fax: 1-646-924-3707**

**Mailing Address:**

**Health Republic Insurance of New York Member Service Team  
30 Broad Street 34<sup>th</sup> Floor  
New York, NY 10004**