Advantica Administrative Services, Inc.
Authorization to Release
Protected Health Information

A. Individual whose information is to be released:

Name: ______________________ Date of Birth: __________

Phone: ______________ Subscriber Name (if different): ______________

I, or my authorized representative, request and authorize <u>Advantica Administrative Services, Inc. (Advantica)</u> to release my personal and health information as described in this authorization.

B. Type of information Advantica may release:

- ☐ Claims information (including amount billed, procedures, claims payment or denial, etc) from dates: ______ to ______
- ☐ Premium information (information on premium payments, billing cycles, bank drafts etc.) from dates ______ to ______
- ☐ Information related to services from ______________ (provider name) for dates: ______ to ______
- ☐ All of my information (personal, health, demographic, claims, billing, medical records, etc.) for dates: ______ to ______
- ☐ Other: ______________________________

C. Who may receive your information?

Individual/Entity Name: ______________________ Phone: ______________

Please indicate how you would like the information sent: ☐ Verbally ☐ Mail ☐ Fax ☐ Secure Email

Street Address: ______________________________

City: ______________ State: ______ Zip: ________ Fax: ______________

Email: ______________________________

I understand that once this information is disclosed, it may no longer be protected by law, and the recipients may possibly re-disclose the information to others without my knowledge or consent.

D. Purpose of Authorization:

- ☐ At my request
- ☐ Other (explain) ______________________________

E. When will this Authorization Expire? (check one)

Note: If I fail to list an expiration date or event below, this authorization will expire one year from the date signed.

- ☐ Upon termination of my coverage
- ☐ On the following date ______________ ☐ On the following event ______________

I understand that I have the right to revoke this authorization at any time and that my revocation must be in writing. I understand the revocation will not be effective for information that Advantica releases between the time that this Authorization is signed and when the revocation is received.

F. Signature Required:

Signature	Date

If a personal representative is signing this authorization for the individual, please complete the following information and provide proof of authority.

Name of Personal Representative	Relationship

I UNDERSTAND I MAY REFUSE TO SIGN THIS AUTHORIZATION

Advantica Administrative Services, Inc. does not condition treatment, payment, enrollment or eligibility for benefits on whether an individual signs this authorization

Returned Completed Form to:

Advantica Administrative Services, Inc.
Attn: Customer Service
PO Box 8510
St. Louis, MO 63126
Fax: (314) 849-4830 or (800) 501-8432