AUTHORIZATION TO RELEASE MEDICAL RECORDS

Name:
SS #: Date of Birth:

I, ____, hereby authorize any hospital, physician or other person who has medically examined me, to furnish International Health, acting as my agent, any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment that were rendered to me. I intend for my agent to be treated as I would be with respect to my rights regarding the use and disclosure, without restriction, of my individually identifiable health information or other medical records. I further authorize my agent to disclose such information to others as may be necessary to arrange treatment, consultation, care or benefit, including insurance or other financial arrangement to satisfy claims for payment made by any provider of services.

This release authority applies to any information, whether or not governed by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 USC 1320d and 45 CFR 160-164. The authority given my agent shall supersede any prior agreement that I may have made with my health-care providers to restrict access to or disclosure of my individually identifiable health information. The authority given my agent has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health-care provider.

I intend that a copy of this form, whether transmitted in physical or electronic copy, shall have the full force and effect of the original.

___________________________________ Date: _____________________
Signature of Member or Legal Representative

____
Relationship to Member if Legal Representative

(Except for Legal Representatives acting in capacity as a parent to the claimant, a copy of the document giving the Legal Representative the authority to sign this Authorization must be attached.)