

# Authorization for use or disclosure of health information



Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Federal law concerning the privacy of such information.

**Failure to provide all information requested may void this authorization.**

I am applying for enrollment in:

**Erickson Advantage® Champion (HMO-POS SNP)**

because I may have one or more of the following qualifying conditions described by this Plan:

<input type="checkbox"/> Diabetes Mellitus	<b>Cardiovascular disorders:</b>	
<input type="checkbox"/> Chronic Heart Failure	<input type="checkbox"/> Cardiac Arrhythmia	<input type="checkbox"/> Coronary Artery Disease (CAD)
	<input type="checkbox"/> Peripheral Vascular Disease	<input type="checkbox"/> Chronic Venous Thromboembolic Disorder

**Use and disclosure authorization**

I, (Insert Applicant Name) \_\_\_\_\_, hereby authorize the disclosure of my health information described above by:

Name of Provider		Provider Telephone Number	
Provider Address	City	State	ZIP Code

to Erickson Advantage® for the purpose of verifying that I have a qualifying medical condition for enrollment in the Plan.

This authorization applies to all the health information maintained by the provider about my medical history or care from *(insert date you first received care from your provider)* \_\_\_\_\_ to present for the condition or conditions that I have indicated above.

This authorization will expire upon the earlier of (1) my not enrolling in the Plan or (2) the termination of my enrollment in the Plan.

I understand the following:

- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf and sent to Erickson Advantage®. My revocation will be effective upon receipt, but will not be effective to the extent that Erickson Advantage® or others have acted in reliance upon this authorization
- I understand that if I refuse to sign this authorization, the application will be considered incomplete
- Information disclosed according to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law

Print Name of Applicant/Member/Authorized Representative	Medicare ID Number
Signature of Applicant/Member/Authorized Representative	Date

**If you are the authorized representative of the applicant, you must provide the following information:**

Relationship to Applicant	Address	Telephone Number
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Erickson Advantage® is insured through UnitedHealthcare Insurance Company and its affiliated companies, a Medicare Advantage organization with a Medicare contract.

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