Automated Group Administration, Inc.

Authorization for Use and Disclosure of Protected Health Information

Please Print:
Member (Patient) Name_____Date of Birth_____

Member (Patient) Address_____AGA ID#_____

I authorize Automated Group Administration, Inc., to use and disclose my (or patient's) protected health information with the following individuals or companies:
Person or Company Name:_____ Phone Number_____

Address_____

Person or Company Name:_____ Phone Number_____

Address_____

Please select any and all information that you want to be shared:
☐ All Healthcare information including any mental health, drug/alcohol abuse, or communicable disease treatment records.
☐ Limit disclosure to all healthcare information, **EXCLUDING** any mental health, drug/alcohol abuse, or communicable disease treatment
☐ Limit disclosure to Benefit/Coverage information
☐ Limit disclosure to Claims Status
☐ Other (please explain)_____
☐ Limit above disclosure to healthcare services provided between the following dates: _____ to _____

Purpose of the disclosure. Please select all that apply.
☐ Personal use or assistance ☐ Assistance with a grievance/appeal ☐ Legal Action (Please specify) ☐ Other (Please specify)
Please describe legal action or other purpose_____

Important Information About Your Rights

I understand that:

- I am not required to sign this authorization to receive my benefits except as allowed by law, as when a disclosure is necessary for AGA to determine payment of a claim.
- I may request a copy of this signed authorization.
- I may change or cancel this authorization at any time by sending a written request to AGA. However, any change or cancellation will not have any effect on any actions AGA took prior to receiving the change or cancellation request.
- The health information indicated above may no longer be protected by federal or state privacy laws.
- If I choose to designate a representative to assist me, the representative will have access to my protected health information.
- **This form will be valid until revoked unless a shorter time period is provided below.**
  My authorization is valid from: _____ to _____

Signature of Member (Patient)_____Date_____

If Patient is under the age of 18 years, or is otherwise unable to sign, a parent or other legally authorized individual should sign below.

Signature for Patient_____Date_____

Please print name clearly_____
Relationship to Patient (Please select):
☐ Parent ☐ Spouse ☐ Legal Guardian* ☐ Power of Attorney*

☐ Other authorized representative (please specify relationship)_____

☐ Authorized as Next of Kin (use if patient is deceased or incapacitated, and no other authorized representative has been designated).
Please specify relationship_____

*Please supply applicable documentation of legal guardianship, power of attorney, or other legal authorization to represent Patient.

7605 Westfield Drive, Fort Wayne, IN 46825 (260) 489-6447 Fax (260) 489-0365