



Member Designated Release of Information

Your medical information is confidential. The completion of this form permits HealthAmerica / HealthAssurance to provide information to the person(s) you name on the attached member designated release of information form. This form is designed to protect your privacy by allowing those person(s) you designate to be able to access your information. For instance, you may have your spouse, your employer or broker, a family member or a friend assist you with your health care benefits. Information that may be shared with the person(s) will be that which is directly relevant to the specific customer service issue for which they may be assisting you. This form does not permit HealthAmerica / HealthAssurance to release information to anyone except the individual or entity you name on the attached form

HealthAmerica / HealthAssurance will **NOT** release information pertaining to HIV/AIDs, alcohol or substance abuse treatment or mental health treatment (all which by law, may require a special form for release), even if a specific claim or authorization question from the person named below is raised. This information will only be released to you or your legal representative (such as legal guardian or verified Health Care Power of Attorney).

Note: You must name your spouse if you want Coventry to release the information identified previously to your spouse.



Member Designated Release of Information

I designate the person(s) named below to receive information from HealthAmerica / HealthAssurance about my benefits, on my behalf, in order to assist me in resolving questions about my health care coverage. I understand that this information may include Protected Health Information and other information protected by law. I agree that HealthAmerica / HealthAssurance may share this information with the person(s) designated below.

By signing this form, I release HealthAmerica / HealthAssurance from any liability of any nature in connection with its release of my Protected Health Information to the person(s) designated below consistent with the terms of this form and any use, misuse or secondary release of such information by the person named below.

I understand that this designation will be effective until I notify HealthAmerica / HealthAssurance otherwise. I understand that I may change or cancel this request by sending my change in writing to the address below.

Member Name: _____

Health Plan Name: _____

Member ID Number: _____

Member Signature: _____ Date: _____

Other Signature: _____

(If someone other than the Member is signing this form; i.e., Health Care Power of Attorney or Legal Guardian, sign your names and your relationship to the member. Attach appropriate documentation to this form if it has not been previously submitted to HealthAmerica / HealthAssurance.)

Designated Individual Information:

Designee Name: _____

Relationship to Member: _____

Designee Address: _____

City, State ZIP: _____

Designee Phone Number: _____

Send this form to:
HealthAmerica / HealthAssurance
PO Box 7089
London, KY 40742

Please keep a copy of this form for your records