AlwaysCare℠
Dental · Vision · Hearing · Life · Disability

Authorization for Release of Health Information

Patient Name: _____ **Date of Birth:** _____

Previous Name: _____ **S.S.#:** _____

Patient Mailing Address: _____

This will authorize AlwaysCare Benefits, Inc. ("AlwaysCare") to use and/or disclose the following protected health information as described below:

1. Specific description of my protected health information (including dates):

_____

2. Persons or Organizations receiving my protected health information:

_____

	Initial
I understand that I may inspect or copy the protected health information which is subject to this Authorization.	_____
I understand that this Authorization may be revoked in writing at any time, by delivery to AlwaysCare, subject to except to any action has already been taken.	_____
I understand that information used and/or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and, if so, may no longer be protected by federal or state privacy laws.	_____
I understand that AlwaysCare shall not condition payment of benefits, enrollment in the Health plan, or eligibility for benefits under the health plan on my providing authorization For the requested use and/or disclosure and THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION.	_____
I understand that AlwaysCare may receive direct or indirect renumeration from the Persons or organizations listed in item 2 above as a result of this authorization.	_____

Date: _____

_____
Signature of patient or representative

_____

AlwaysCare Benefits, Inc.
(a Starmount Life Insurance company)
7800 Office Park Blvd.
Baton Rouge, LA 70809
Phone: 225-926-2888 • Fax: 225-926-6292

Relationship of representative to patient

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