

## Member Requested Authorization for Release of Information

Please read these instructions carefully before completing this form.

### **When to Use This Form**

You must complete this form if you want SelectAccount to give information about you to someone else (for example: an agent or family member).

Parents or a legal guardian may sign for a minor unless the minor is permitted under state law to consent to the treatment. In that case, the minor must sign the authorization.

### **How to Complete This Form**

The Authorization for Release of Information form must be completed and signed by one of the following:

- ◆ The person whose information will be released
- ◆ The parent or legal guardian of a minor whose information will be released except as listed above
- ◆ The personal representative of the person whose information will be released (e.g., power of attorney, conservator, legal guardian, executor)

To complete this form:

- ◆ Fill in the name, member identification and date of birth of the person whose information will be released.
- ◆ Check the type(s) of information you want us to release.
- ◆ Fill in the name and address of the person or employer who will receive the information.
- ◆ State the purpose for this authorization for release.
- ◆ Sign and date the form.
- ◆ If you are not the person whose record will be released, state your relationship to that person

### **Mail or fax this form to**

SelectAccount  
P.O. Box 64193  
St. Paul, MN 55164-0193  
Fax: 651-662-7247 or 1-866-231-0214

### Member Requested Authorization for Release of Information

**Member Information (person granting release of information)**

Member Name \_\_\_\_\_

Member ID \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Group Name: \_\_\_\_\_

**I authorize SelectAccount to release the following information (check one or more types)**

- Address, date of birth, membership status
- Account Financial Information (Balances, Deposits, Withdrawals)
- Claims
- Other, please specify \_\_\_\_\_

**SelectAccount may release this information to:**

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_

Email Address \_\_\_\_\_

**Purpose for this Release**

- Request of member or personal representative
- Other, please specify \_\_\_\_\_

If the information relates to payment for alcoholism or drug dependency expenses, we must have the name of the treatment facilities or program(s): \_\_\_\_\_

If the information relates to payment for alcoholism or drug dependency expenses, I understand that the person(s) I have named to receive the information must treat it as confidential. The information cannot be disclosed again without another signed authorization from me. For all information other than payment for alcoholism or drug dependency expenses, I understand that the person(s) I have named to receive information may not be subject to privacy laws. They may be able to release the information, and privacy laws may no longer protect it.

**Right to Revoke** - I understand that I may cancel this authorization in writing at any time, but it will not affect any release of any information processed before I cancel it.

This authorization is valid for one year after the date it is signed, unless an earlier expiration date is indicated here: \_\_\_\_/\_\_\_\_/\_\_\_\_.

\_\_\_\_\_  
Signature of Member

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent or other Personal Representative

\_\_\_\_\_  
Date

If this request is by a personal representative on behalf of the member, complete the following:

Personal Representative's Name \_\_\_\_\_

Relationship to Member \_\_\_\_\_

**Note:** You have a right to keep a copy of this notice after you sign it.