

Authorization

I _____ (print name) authorize the use or disclosure of health information that could be used to identify me (called "Protected Health Information") as described below. Protected Health Information ("PHI") is any information that relates to: (1) My past, present or future physical or mental health or condition; (2) Health care I have received or will receive; and/or (3) Payment for health care I have received or will receive.

I am naming **All UAW Benefit Representatives** as my Authorized Representatives(s) to submit this claim information to my Health Care Plan/Carrier on my behalf and I authorize the Health Care Plan/ **Delta Dental** (Carrier) to provide my Authorized Representative(s) with the PHI described herein.

I authorize the use or disclosure of the following PHI to my Authorized Representatives(s): (Please check the appropriate box)

- PHI that is relevant to review of the claim(s) identified on the attached Claims Appeals/Inquiry Form
- Other (Please indicate specific PHI, for example: EOB statements, claims information, provider reports, ect.)

I agree that my PHI will only be used or disclosed for the following purpose(s): (Please check the appropriate box)

- To ONLY resolve the issue(s) identified on the attached Claims Appeals/Inquiry Form
- Other (Please describe the specific uses and disclosures)

This authorization expires on the earlier of _____ or the following event: (Please check the appropriate box)

- Resolution of the issue(s) identified on the attached Claims Appeals/Inquiry Form
- Other (Please Describe the Event that Terminates this Authorization)

Upon termination of GM group coverage through Delta USA

I understand that:

- (1) PHI disclosed in reliance on this Authorization may be re-disclosed and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996.
- (2) I have the right to revoke this Authorization in writing at any time, except to the extent the Health Care Plan and/or **Delta Dental** (Carrier) has taken action in reliance upon this Authorization, by submitting a written request to the Carrier.
- (3) This Authorization is voluntary and that I may refuse to sign this Authorization. My refusal to sign will not affect my eligibility for Plan benefits or my enrollment in or coverage under the Plan.

I have read and understand the above, I agree to the terms of this Authorization, and I understand that the disclosure is being made at my request.

Signature of Individual or their Personal Representative

Date