Medical Records Release & Authorization for Use or Disclosure of Protected Health Information

Patient Name: ______________________ Phone #: ______________

Address: ____

I authorize the custodian of records to disclose/release the following information* (check all applicable):

- ☐ All records needed to determine claims/benefits
- ☐ Laboratory/pathology records
- ☐ X-ray/radiology records
- ☐ Billing records (Itemized Bill)
- ☐ Abstract/Summary
- ☐ Pharmacy/precription records
- ☐ Other (describe specifically) ______________________

**Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, yo uare hereby authorizing disclosure of this information.*

These records are for services provided on the following date(s): ______________________

The information may be used/disclosed for each of the following purposes:

- ☐ For payment/benefits
- ☐ Other: ______________________

This authorization shall expire upon final resolution of my claim for benefits.

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information

______________________ ______________

Signature (Patient or Parent/Guardian) **Date**

______________________ ______________

Printed Name **Representative's Title**

Please send the records listed above to:
Paragon Benefits, Inc.
Attn: Customer Service
P.O. Box 12288,
Columbus, GA 31917
Fax: 706.256.4089
Phone: 800.277.9218

You have the right to revoke this authorization, except to the extent the custodian of records has relied on it, by sending in a written revocation to the custoidan of records.