

NEW WEST HEALTH SERVICES

& New West Health Plan

Individual Health Insurance Enrollment Application



**130 Neill Avenue
Helena, MT 59601
(406) 457-2200 (Helena)
Toll Free: (888) 500-3355**



Enrollment Application



Directions & Purpose

Complete ALL pages (2-8)

- New Application
- Add Dependents

Complete ONLY Pages 2 & 7

- Drop Dependents
- Change Coverage
- Name Change

Complete ONLY Page 2, 3 & 7

- Conversion

Applicant's Information

Last Name		First Name		Middle Initial	
Mailing Address					
City	State	ZIP	Social Security Number	Date of Birth	
Daytime Telephone Number (include area code)			Evening Telephone Number (include area code)		
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married			Date of Marriage		

Type of Membership Requested

- Applicant only
- Applicant and spouse
- Applicant and unmarried child(ren)
- Applicant, spouse & unmarried child(ren)

Requested effective date (The effective date must be the first of the month following receipt of the application – subject to New West's approval) Date ____ / ____ (month and year)

Product Selection

Product Name and Deductible Amount:	Additional Plan Benefits
	<input type="checkbox"/> Vision (Not available with Premier-West or <input type="checkbox"/> Dental (Valu-West policies.)

Household Information

APPLICANT AND ALL FAMILY MEMBERS applying for coverage must be listed below. All persons requesting coverage under an individual policy are subject to eligibility guidelines. If applicable, include any court documents verifying adoption, placement for adoption, legal guardianship, conservatorship, custody orders and/or the existence of a qualified medical child support order.

Last Name	First Name	MI	Social Security Number	Date of Birth	Sex (M/F)	Relationship to Employee (self, spouse, son, daughter)

Have you ever applied to, or been insured by New West? If so, please provide the name of the person that provided you (or any family members) coverage.

Date of Application/Coverage: _____ Name of Insured: _____

Employer Information

Please answer the following questions:	Yes	No
1. Will a portion of the premium for this policy be paid by or on behalf of an employer (under 50 employees), either directly or through wage adjustment or other means of reimbursement?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the applicant intend to treat this policy as part of a plan or program using a medical savings account, health savings account, qualifying as a cafeteria plan or deductible as a trade/business expense?	<input type="checkbox"/>	<input type="checkbox"/>
➔ If yes, will any part of that plan or program be funded by the applicant's employer?	<input type="checkbox"/>	<input type="checkbox"/>

Payment Information

Payment Frequency	<input type="checkbox"/> Monthly (<i>EFT or Credit Card only</i>)	<input type="checkbox"/> Semi-annual	<input type="checkbox"/> Annual
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Payment Method

<input type="checkbox"/> Check	I would like to pay the premiums by check and I understand that checks are accepted for a billing frequency of semi-annual or annual only. Other payment arrangements may be made through electronic bank drafts or credit cards.		
<input type="checkbox"/> Bank Draft Option (EFT)	I would like my premium charged to my bank account and have attached a voided check.		
	Type of account <input type="checkbox"/> Checking <input type="checkbox"/> Savings	Name of Bank	Bank Routing Transit Number
<input type="checkbox"/> Credit Card Option	I would like my premium charged to my credit card.		Credit Card Number
	Type of Credit Card: <input type="checkbox"/> Visa/MC <input type="checkbox"/> AMEX	<input type="checkbox"/> Discover <input type="checkbox"/> Other: _____	

Credit Card/Bank Draft (EFT) Payment Agreement

As a convenience to me, I hereby authorize New West to initiate a charge to my credit card/bank account payable to the order of New West. I agree that New West's rights with respect to each such credit card charge/bank draft shall be the same as if it were a check drawn on my bank account and signed by me personally. This authority is to remain in effect until the last applicable premium is paid, or until revoked by me in writing and received by New West, whichever is sooner. I agree that if such charges are dishonored, whether with or without cause and whether intentionally or inadvertently, New West shall have no liability whatsoever even though dishonor results in forfeiture of insurance. The first month's premium will be charged upon this Application's acceptance. I understand that my credit card/bank account will not be charged if this Application is declined.

Name and Address of Credit Card/Bank Account Holder (Print):

Signature of Account Holder (It must be EXACTLY as it appears on credit card/bank account records)	Relationship of Applicant to Account Holder:
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Other Coverage or Creditable Coverage
(Attach and sign additional sheets, if necessary.)

Please answer the following questions:		Yes	No
1. Have you and/or your dependents had health coverage within the last 30 days? Notice: Benefits under the Plan are subject to a pre-existing conditions exclusion period of twelve (12) months, beginning on the effective date of coverage. If you have not had a lapse in coverage of more than 30 days, the pre-existing condition exclusion period will be offset by any proof of eligible creditable coverage you or your dependants submit to New West.		<input type="checkbox"/>	<input type="checkbox"/>
→ If yes, attach verification(s) and/or certificate of creditable coverage to this Application.			
→ If yes, list name of person(s) with creditable coverage:	Name, Address and Phone Number of Company(ies)/Carrier(s) Providing the Creditable Coverage:	Policy Number(s):	
2. Is anyone applying for coverage currently insured with another company/carrier?		<input type="checkbox"/> Y	<input type="checkbox"/> N
→ If yes, list name of person(s) with other coverage:	Name, Address and Phone Number of Other Company(ies)/Carrier(s):	Policy Number(s):	
3. At any time have you and/or your dependents received benefits or compensation for an occupational injury, accident, illness or disease?		<input type="checkbox"/> Y	<input type="checkbox"/> N
→ If yes, list name of person(s):	Specifically describe injuries, illness or disease and the date of onset, injury or accident:		
4. Are you and/or your dependents currently continuing coverage under COBRA?		<input type="checkbox"/> Y	<input type="checkbox"/> N
→ If yes, list name of person(s) with COBRA coverage:	Name, Address and Phone Number of Company(ies) or Carrier(s) Providing COBRA Coverage:	Date COBRA Began:	Qualifying Event: Policy Number(s):

Medical History

(Mark **Yes** or **No** to every question for ALL family members to be covered.)

1. Within the lifetime of any person applying for coverage, has any person applying for coverage ever had any reason to know of, or consulted with a provider of health care services for medical advice, diagnosis, care or treatment for any of the following:	Enrollee		Spouse		Children	
	Yes	No	Yes	No	Yes	No
A. Diabetes, hypoglycemia, or any glandular disorder, including but not limited to, thyroid or recurrent enlarged glands?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Rheumatic fever, abnormal blood pressure, high cholesterol levels, or any heart disorder, including but not limited to heart attack, angina pectoris, stroke, palpitations, chest pain, irregular pulse, heart murmur, or valve prolapse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Any disease of the stomach, gall bladder or liver, including but not limited to ulcers, gallstones, jaundice, colitis, diverticulitis, diverticulosis, bleeding from the intestinal tract, Crohn's disease, or other disorder of the gastrointestinal system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. A mental disease or emotional disorder, including, but not limited to depression, anxiety, schizophrenia, attention deficit disorder, attention deficit disorder with hyperactivity or any other form of mental disease, condition or illness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. A disease of the brain or nervous system, including but not limited to epilepsy, convulsion, multiple sclerosis (MS) or Parkinson's disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Any form of cancer including but not limited to carcinoma, lymphoma, sarcoma, melanoma, or leukemia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Any disease of the female organs, including but not limited to fibroid uterus, endometriosis, cysts, dysmenorrhea (difficult/painful menstruation), menometrorrhagia (irregular and/or excessive bleeding during and between menses), abnormal pap smear or biopsy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Any disease of the male organs, including but not limited to undescended testicles, hydrocele, epididymitis, or diseases of the prostate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Any diagnostic testing and or treatment related to the reproductive tract or the process of conception?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Any sexually transmitted disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K. Any disease of the lungs or respiratory system, including but not limited to asthma, tuberculosis or emphysema?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L. Any injury or disease of the back or spine, or disorder of the muscles, bones or joints, including but not limited to arthritis, spondylitis, spondylolisthesis or muscular dystrophy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M. Lupus, autoimmune disease or disorder, Epstein-Barr, chronic fatigue or fibromyalgia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
N. Alcohol or controlled substances abuse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
O. Any other illness, disease or injury?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P. Has any person applying for coverage tested positive for HIV or its antibodies, or been diagnosed or treated by a provider of health care services for Acquired Immune Deficiency (AIDS) or AIDS related complex (ARC)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q. Been declined for life, health or accident insurance, medically discharged from the armed services for a physical or mental condition, been disabled or received any pension or other employee benefits for disability, illness or accident?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Medical History (continued)

For each "Yes" answer to question 1 (A-Q), complete the following (attach separate sheet if necessary):

Name of Person	Condition	Treatment Dates		Hospitalized?	Complete provider name, address, city state, ZIP code
		From	To		

2. In the last 10 years, has any person applying for coverage:	Enrollee		Spouse		Children	
	Yes	No	Yes	No	Yes	No
A. Had abnormal results on any blood test, urinalysis, electrocardiogram, X-ray, CT or MRI scan or other diagnostic test?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Been advised to have surgery, medical tests, diagnostic procedures, stress tests, X-rays, urine tests, etc?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Been admitted to a hospital or other medical or rehabilitation facility?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

For each "Yes" answer to question 2 (A-C), complete the following (attach separate sheet if necessary):

Name of Person	Condition	Treatment Dates		Hospitalized?	Complete provider name, address, city state, ZIP code
		From	To		

3. Do you now take, or in the last 5 years have you taken any prescription drugs?	Enrollee		Spouse		Children	
	Yes	No	Yes	No	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

For each "Yes" answer to question 3, complete the following (attach separate sheet if necessary):

Name of Person Taking Medication	Name of Medication	Dates Medication Taken		Dosage & How often refilled	Complete provider name, address, city state, ZIP code
		From	To		

4. In the last 5 years (unless otherwise stated), has any person applying for coverage consulted with or received medical advice or treatment by a physician or medical practitioner for any of the following?	Enrollee		Spouse		Children	
	Yes	No	Yes	No	Yes	No
A. Polyp, cyst or tumor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Any disorder of the blood or blood vessels, including but not limited to varicose veins or anemia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Any skin disorder, including but not limited to acne, psoriasis, or eczema?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Any disorder of the eyes, ears, nose or throat, including but not limited to speech impairment, loss of sight or loss of hearing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Any significant weight loss or weight gain, shortness of breath, chest pain or irregular pulse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Any type of hernia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Appendicitis or persistent diarrhea?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Fainting or loss of consciousness, severe headaches, migraine headaches or constant nervousness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Medical History (continued)

4. (continued)	Enrollee		Spouse		Children	
	Yes	No	Yes	No	Yes	No
I. Any allergies, pleurisy, hay fever, persistent hoarseness, chronic cough or bronchitis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Symptoms of any type of disease, sickness or health impairment not mentioned above, or any other causes for which you have been treated, hospitalized or consulted a physician?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K. Do you now use tobacco or have you used tobacco in the last four years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L. In the last 12 months, have you had, has a physician recommended or do you plan to have any type of diagnostic or medical testing, including but not limited to X-rays, MRI, CT scans, blood work or urinalysis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

For each "Yes" answer to question 4 (A-L), complete the following (attach separate sheet if necessary):

Name of Person	Condition	Treatment Dates		Hospitalized?	Complete provider name, address, city state, ZIP code
		From	To		

	Enrollee		Spouse		Children	
	Yes	No	Yes	No	Yes	No
5. Have you ever been or do you plan to be a surrogate mother?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Are you or any of your dependents now pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Is any person not named on this Application now pregnant by any person to be insured?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Below, list all pregnancies for you and your dependents, any complications of those pregnancies and the method of delivery, i.e., vaginal or C-section. (Attach separate sheet if necessary).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Name of Person	Delivery Date	Complications	Vaginal or C-section Delivery

10. Within the last 5 years, have you had a checkup or annual physical? Please list the most recent Pap test, mammogram, blood test, PSA test, lipid profile or any other tests with results in the box below for all family members. (Attach separate sheet if necessary). If any of the persons applying for coverage have not had a physical examination in the last two (2) years, an examination may be required at your expense during the Application process.	Enrollee		Spouse		Children	
	Yes	No	Yes	No	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Name	Date of Exam	Doctor/Clinic (Include complete mailing address)	Results

11. Provide the height and weight of each person applying for coverage.		
Name of Person	Height	Weight

**Application Agreement
(Please Read Carefully)**

I (represents each person applying for coverage,) understand and agree that:

1. This is an Application only. No rights to coverage are conferred on any of the persons applying for coverage until New West accepts this Application and the applicable premiums are paid.
2. I should not cancel any existing insurance or coverage unless I am notified in writing by New West of my acceptance for coverage. I acknowledge that any of the persons applying for coverage may not be accepted for coverage and may be permanently excluded from coverage.
3. If a broker or agent is handling this coverage request, the broker or agent does not have the authority to bind or commit New West in any manner.
4. New West relies upon the information I provided on this Application and any other information I provided for New West to make a determination about issuing coverage. If the information in the Application is misrepresented, the coverage may be denied or the policy may be cancelled retroactively to the original effective date. I have a continuing obligation to update this Application so that it reflects an accurate and current representation of the health of the persons applying for coverage until the date the Application is accepted by New West.
5. Acceptance of premium by New West does not constitute a waiver of the rights of New West to retroactively cancel my coverage for intentional omissions, misrepresentations, fraud, or concealment of any facts on the Application. If such a retroactive cancellation occurs, New West may deduct benefit payments from any paid premium before refunding such premiums to me. I agree to repay any benefit payments to which I was not entitled.
6. Premiums for the coverage must be paid on time in accordance with the payment option I selected above and failure to pay any premium when due will result in cancellation of the coverage as of the last day of the month for which my last premium was paid.
7. I must be a resident of Montana to be eligible for coverage. If, at any time, I move outside of the state of Montana, I will no longer be eligible for coverage with New West and my coverage will be cancelled. I understand I have an obligation to keep New West up-to-date concerning my residency.

I certify that each person listed on this Application and applying agrees to the terms and conditions of any policy issued to me (us) by New West.

I certify that all of the information provided in this Application or other information provided to New West by me is true, complete and correct to the best of my knowledge.

I have received the New West Notice of Privacy Practices.

I hereby apply for coverage with New West and agree that the coverage for which I am applying is subject to eligibility requirements, and the policy effective date will be assigned by New West. I have read, understand and agree to the terms of the Application Agreement.

All persons 18 years old and over applying for coverage must sign below.

Signature(s)	Date	Signature(s)	Date
Applicant		Spouse	
Child age 18 and older		Child age 18 and older	

Important Reminder: Complete the Conditioned Authorization on the next page for each person applying for coverage.

To Be Completed By Your New West Representative		Yes	No
Have you advised the Applicant to read, fully complete and sign this Application for individual coverage to the best of the Applicants' knowledge and ability?		<input type="checkbox"/>	<input type="checkbox"/>
Have you advised Applicant that coverage will not commence until he/she is notified that that Application for individual coverage has been received and accepted by New West?		<input type="checkbox"/>	<input type="checkbox"/>
Have you advised the Applicant that if the Application for individual coverage does not contain an accurate representation of health for each person applying for coverage, coverage may be rejected or terminated retroactively to its effective date?		<input type="checkbox"/>	<input type="checkbox"/>
Have you explained the pre-existing condition exclusion period to the Applicant?		<input type="checkbox"/>	<input type="checkbox"/>
Have you checked to ensure that there is a completed Conditioned Authorization for each person for whom coverage is requested?		<input type="checkbox"/>	<input type="checkbox"/>
Have you provided a photocopy of any and all completed Conditioned Authorizations to the Applicant for his/her records?		<input type="checkbox"/>	<input type="checkbox"/>
Signature of Representative		Date	
Representative Printed Name		Telephone Number	

Conditioned Authorization To Release Medical Information

TO: ANY DOCTOR, HOSPITAL, CLINIC, X-RAY LAB, TECHNICIAN, OR ANY OTHER MEDICAL ORGANIZATION, OFFICE, FACILITY AND AGENCY

Patient Information (Complete One Form Per Person – Copy as Needed) Name: _____ Date of Birth: _____ Social Security Number: _____	Release Information to: New West Health Services Attn: Underwriting Dept. 130 Neill Avenue Helena, MT 59601
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Purpose of this Authorization: By signing this form, you will authorize the disclosure and use of the protected health information described below for pre-enrollment underwriting or risk-rating of health insurance coverage for you, or to determine your eligibility for enrollment or benefits under a health insurance policy.

Effect of Granting or Declining this Authorization: If you sign this authorization, the protected health information described below may be disclosed to and/or received by persons or organizations that are not subject to federal health information privacy laws. These persons or organizations may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws. This authorization is a condition of your enrollment in or eligibility for benefits under a health insurance policy. If you decide not to sign this authorization, we may decline to enroll you in a health insurance policy or to give you the benefits.

Expiration: Unless earlier revoked, this authorization will expire **one (1) year** after the date of this authorization.

Right of Revocation: You may revoke this authorization at any time by giving written notice of revocation to the Compliance Officer, New West Health Services, 130 Neill Avenue, Helena, MT, 59601. Revocation of this authorization will *not* affect any action we took in reliance on this authorization before we received your written notice of revocation. Revocation of this authorization may mean that we terminate your health insurance policy and/or end your eligibility for benefits.

Information Requested for a five year period ending on the date of the signature below.

- Non-Medical Information (including but not limited to information related to eligibility, coverage, claims, benefits, providers, family members and demographics)
- Copy of All Medical Information and Records (including but not limited to HIV/AIDS related health information and mental health information and records)
- Drug/Alcohol Diagnosis, Treatment and/or Referral Information (including, but not limited to, treatment plans, assessments, testing and test results, evaluations, discharge summaries, medication prescriptions and prescription monitoring, counseling session start and stop times, treatment modalities and frequencies, and any summary of the following items: diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date. *This does not include Psychotherapy Notes.*

Individual's Signature. *The authorization must be signed by the individual, if the individual is age 16 or older, about whom the health information to be released pertains.*

I, _____, have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization of the use and/or disclosure of my protected health information, as described in this form.

Signature of Individual

Date

Printed Name

If this authorization is to release information for a child under 16 years old who is not emancipated or an incapacitated person, please sign below. If your relationship with the individual is other than as a parent of the child, a copy of the legal document establishing you as the individual's legal representative must be attached to this authorization.

Signature of Parent/Legal Representative/ Guardian

Date

Printed Name

Relationship to Individual

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.