



**Authorization for Disclosure of Protected Health Information**

My protected health information is information about me, including information such as my name, address, social security number, date of birth and/or medical information. The information was used or created when I received health care or when payment was received for my health care. The information may include my past, present or future physical or mental health or condition.

Name: \_\_\_\_\_ Member ID/SSN: \_\_\_\_\_

Address: \_\_\_\_\_ DOB: \_\_\_\_\_

\_\_\_\_\_  
Telephone: \_\_\_\_\_

\_\_\_\_\_  
Email: \_\_\_\_\_

Group Name: \_\_\_\_\_ Plan Name: \_\_\_\_\_

I hereby authorize Gallagher Benefit Services, Inc. (located at Five Greentree Centre, Suite 104, Marlton, NJ 08053), and its affiliates to disclose and/or receive confidential information pertaining to the member/insured named above.

This release is for (please complete):

Carrier/Provider Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

This release is for the purpose of (please check all that apply):

- Coordination of benefits
- Claim resolution
- Payment resolution
- Other: \_\_\_\_\_

Gallagher Benefit Services, Inc. agrees to maintain my protected health information in accordance with its privacy policy practices.

This authorization will expire on \_\_\_\_\_ or on occurrence of the following event \_\_\_\_\_ which relates to the purpose of the use and/or disclosure being authorized. If no date is specified, this authorization will automatically expire in six (6) months from the date originated.

You may revoke this authorization at any time by providing written notification to Gallagher Benefit Services, Inc. Your revocation of this authorization will not affect any action we have taken before we receive your notice of revocation.

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

Authorized Representative/Guardian (if under 18): \_\_\_\_\_