Authorization for Release of Protected Health Information

Employee

I, (print name) ____________________________________, (social security #) ________________________, a participant in the (employer name) ____ Health Benefit Plan, subsequently known as The Plan, authorize The Plan and ADN Administrators, Inc, to disclose claims payment, eligibility and other related health information about me to the following persons (select 1-2 persons if desired), at the request of such persons:

Name: ____ Relationship: ________________________

Name: ____ Relationship: ________________________

I understand that this authorization will not expire, unless I revoke it. I understand that I have the right to revoke it at any time, except to the extent that it has already been relied upon. I understand that if I decide to revoke this authorization, I must give notice of my decision in writing and send it to ADN Administrators, Inc.

I understand that health information disclosed pursuant to this authorization may be redisclosed by the persons I have authorized above, and that the Plan cannot prevent or protect such redisclosures. I understand that I am not required to sign this form to receive my health care benefits (enrollment, treatment or payment).

Signature of Employee: ____ Date: _________________

Spouse

I, (print name) ____, the spouse of the above named and identified employee, have read the above Employee section and understand its terms. I authorize the Plan to disclose claims, payment, eligibility or other related health information about me to the following persons (select 1-2 persons if desired) for the reasons stated and subject to the conditions listed in the Employee section above, at the request of such persons:

Name: ____ Relationship: _______________________

Name: ____ Relationship: _______________________

Signature of Spouse: ____ Date: _________________

Adult Dependent Child

I, (print name) ____, the dependent child over the age of 18 of the above named employee have read the above employee section and understand its terms. I authorize the Plan to disclose claims, payment, eligibility and other related health information about me to the following persons (select 1-2 persons if desired) for the reasons stated and subject to the conditions listed in the employee section above, at the request of such persons:

Name: ____ Relationship: _______________________

Name: ____ Relationship: _______________________

Signature of Adult Dependent: ____ Date: ______________