



**AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH PLAN INFORMATION
(Authorized Representative)**

This authorization will remain in effect until (a) the date you specify; (b) the date enrollment ends; or (c) the date you withdraw your permission.

**Mail this form to: AvMed
Compliance/Privacy
PO Box 66189
Virginia Beach, VA 23466

or email to: shpprivacy@sentara.com

Privacy Statement: Please be aware that email and text communication can be intercepted in transmission or misdirected.

Step 1: Complete the demographic information for the person receiving services.

1. _____ Name
2. _____ / _____ / _____ Date of birth
3. _____ Member ID # or last four digits of SSN number
4. _____ Phone number (specify if mobile number)
5. _____ Street address, city, state, and zip

Step 2: Tell us what health plan information may be used or disclosed.

6. Check the appropriate box to indicate what information may be used or disclosed:
 Claims information Healthcare provider Address Account information
 Clinical information Other (see instructions) _____

Step 3: Tell us who you are authorizing to use or receive your health plan information.

7. _____ Name of authorized person _____ Relationship to person receiving services
8. _____ Address of authorized person _____ Mobile phone number or email of authorized person
9. OPTIONAL: Authorization termination date: _____ / _____ / _____
Month Day Year



INSTRUCTIONS FOR AUTHORIZATION COMPLETION

1. Do not skip any steps. Fill in all information as completely as possible.
2. Step 1, 1-5: This is **the Member's** name, date of birth, Member's insurance number, phone number, and address.
3. Step 2, 6: This is the information you authorize AvMed to disclose to your representative. The "other" section allows you to write in a specific description of the health plan information or name of the documents not on the checklist. Example: "Claims for Dr. Smith from 2/1/2009 to 2/1/2010."
4. Step 3, 7-8: This is the name and the address of the person whom you wish to have access to the Member's information.

Step 3, 9: This allows you to determine if and when you want this form to expire.
5. Step 4, 10-11: This is **the Member's signature** or the signature of the person who has the legal authority to sign this type of document on behalf of the Member. This section is for drug and substance use medical records.
6. Step 5, 12: This is **the Member's signature** or the signature of the person who has the legal authority to sign this type of document on behalf of the Member.
7. Step 5, 13: This is the relationship between the Member and the person who has the legal authority to sign documents for the Member. **ONLY** fill this line out **IF** someone other than the Member signed the form.

Call Member Services if you have questions/concerns regarding this authorization form:

Employer Group and Individual & Family Plan members, call Member Services at the number on the back of your member ID card. (TTY: 711), Monday–Friday, 8 a.m. – 8 p.m. and Saturday 9 a.m. to 1 p.m.