

**AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION**

**Patient Name:** \_\_\_\_\_  
**Insured Name:** \_\_\_\_\_  
**Insured I.D.:** \_\_\_\_\_  
**Insured By:** \_\_\_\_\_  
**Relationship to Patient:** \_\_\_\_\_

I hereby authorize **Fidelity Benefit Administrators, Inc.** or their designee, to release and/or disclose verbally and/or in writing the above named individual’s health information as requested regarding medical care and services provided

**To:** \_\_\_\_\_ **For the purpose of:**  Claims Status Inquiry  
\_\_\_\_\_  
\_\_\_\_\_  
*(Fill in HR Contact or Broker and Address)*

**Copies of Information Requested:**  
 Reports of Claims Payment  
 General Information necessary to respond to inquiry  
 Other \_\_\_\_\_

I understand that my records are protected under federal regulations governing Confidentiality of Personal Health Information (PHI) under HIPAA, and cannot be disclosed without my consent unless otherwise provided for in the regulations. I also understand that I may revoke this authorization and must do so in writing and present the written revocation to the Privacy Officer of FBA. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this consent expires 12 months from this date. I understand that once information is disclosed per my authorization, the information may be redisclosed by the recipient in accordance with applicable laws and regulations and it may not be protected by federal or state privacy regulations.

If I have questions about disclosure of my health information, I can contact the Privacy Officer at FBA at (410) 329-0900. A duplicate photo static copy or facsimile reproduction of this authorization may be used in lieu of the original. I understand that I may keep a copy of this authorization form, after signing for my records.

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Parent, Guardian, or Authorized Representative Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Witness Signature**

\_\_\_\_\_  
**Date**

