



**CORE**  
MANAGEMENT  
RESOURCES

## INDIVIDUAL AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

This authorization is not valid unless it is filled out completely. This form cannot be used as a joint authorization with another member; therefore, each member must submit an individual form. Please type or print the information.

**1. MEMBER** (Name and information of person whose protected health information is being disclosed):

NAME \_\_\_\_\_ D.O.B. \_\_\_\_\_  
GROUP # \_\_\_\_\_ MEMBER ID# \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
PHONE # \_\_\_\_\_

**2. AUTHORIZATION and PURPOSE**

I request and authorize Core Management Resources to disclose my protected health information to the following Persons/Organizations:

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
PHONE # \_\_\_\_\_ PURPOSE \_\_\_\_\_  
ADDRESS \_\_\_\_\_

**3. PROTECTED HEALTH INFORMATION**

I authorize access of the following information (*check one or more*):

- |  |  |
|--|--|
| <input type="checkbox"/> Any information requested   | <input type="checkbox"/> Benefit information                 |
| <input type="checkbox"/> All claims information  | <input type="checkbox"/> Explanation of Benefits information |
| <input type="checkbox"/> Access to information listed on <i>CoreLink II</i> (online claim website) | <input type="checkbox"/> Enrollment information              |
| <input type="checkbox"/> Other (please specify) _____  |  |

**4. EXPIRATION**

This authorization will expire on (*must choose one*):

- ☐ One year from the date form is signed    ☐ Other (insert date or event) \_\_\_\_\_

**5. EXPLANATION OF RIGHTS.** I understand that:

- I have the right to refuse to sign this authorization; refusal to sign will not adversely affect my ability to receive health care services or reimbursement for services.
- I have the right to inspect or receive a copy of the protected health information that will be used or disclosed by Core.
- The information used or disclosed pursuant to the authorization may be subject to re-disclosure and may no longer be protected by the regulations that require payers to protect individual health information.
- I can revoke this authorization at any time by submitting a written request to the address below.

Return the completed form by:

**FAX** (478)-745-1843

**EMAIL** [help@corehealthbenefits.com](mailto:help@corehealthbenefits.com)

**MAIL** Privacy Officer  
Core Management Resources Group, INC.  
PO Box 1755  
Macon, Georgia 31202

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Member

\_\_\_\_\_  
Printed Name of Member

\_\_\_\_\_  
Authority of Personal Representative  
(If signing for the Member)