



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 Information

NAME _____ D.O.B. _____

ADDRESS _____

PHONE # _____ SOCIAL SECURITY # _____

2. Subscriber Information

(The Subscriber is usually the Employee who obtains coverage for his or her family. Please complete this Section if the Subscriber is not the member whose records are being requested.)

NAME _____ D.O.B. _____

ADDRESS _____

PHONE # _____ SOCIAL SECURITY # _____

3. I authorize access of the following information:

- | | |
|---|---|
| <input type="checkbox"/> Claim Summary | <input type="checkbox"/> Copies of Explanations of Benefits |
| <input type="checkbox"/> Claim Detail | <input type="checkbox"/> Access to All Information Available Through <i>CoreLink II</i> |
| <input type="checkbox"/> Copies of Claims | (Core's On-line Enrollment and Claim Service) |
| <input type="checkbox"/> Eligibility | <input type="checkbox"/> Other (please specify) _____ |
| <input type="checkbox"/> Access to All of the Above | |

To the following person or class of persons:

NAME _____ PHONE # _____

ADDRESS _____

4. Unless revoked, this Authorization shall be in force and effect until the following (check one):

- ☐ Date: _____
- ☐ 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 following:

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

Date

Signature

Print Name

Authority of Personal Representative
If signing for the Member