MORGANWHITE ADMINISTRATORS, INC.

Please complete and return by fax to (601) 956-1147
e-mail to: Claims@morganwhite.com
or mail to: Morgan-White Administrators, Inc.
P.O. Box 16708
Jackson, MS 39236-6708

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

This form is used to authorize Morgan-White Administrators (MWA) to disclose an Insured's Protected Health Information to the individuals or organizations named in this form.

A. MEMBER INFORMATION – This is the individual whose information will be released.
(Individuals over 18 years of age must complete their own form, except for legal Personal Representative situations).

Insured's Name: _____
Address (Street, City, State, and Zip Code): _____
Telephone Number: _____ Insured's SSN: _____

B. AUTHORIZED PARTY – This is the person or organization who will receive the Insured's information.

I authorize MWA to release the above Insured's Protected Health Information to:

_____ _____

_____ _____

C. INFORMATION TO BE RELEASED – If limiting disclosures, please describe. ***Check one box only***

☑ ALL information relating to provision or payment of healthcare benefits or services may be released.
☐ Other (please describe): _____

D. EXPIRATION AND REVOCATION – When this authorization will end. ***Check one box only***

Expiration: ☑ Six (6) months after termination of MWA coverage. (This option will apply if no other option is selected.)
☐ On this specific date _____ or occurrence of this event: _____

Revocation: You may revoke this Authorization at any time by notifying MWA in writing. Your revocation will not affect any action MWA took before your revocation was received. To revoke this Authorization, please contact MWA Compliance.

E. SIGNATURE – Please sign and date below.

This authorization is voluntary and completed at my own request. I understand that if the person or organization I have authorized to receive the information is not subject to federal health information privacy laws, the information may be re-disclosed and no longer be protected by federal privacy laws. I understand that giving this Authorization is not a condition of enrollment in a health plan or eligibility for benefits. This Authorization is not valid unless completely filled out, signed and dated by the Insured or by the Insured's legal Personal Representative.

_____ _____

Signature of Insured (or Insured's Personal Representative)** **Date**

****If the Insured is a dependent minor child, the child's parent or legal guardian must sign this form. This form may **not** be signed on behalf of the Insured by a spouse or parent of an individual 18 years of age or older unless they are the Insured's legal Personal Representative and provide proof of this authority to MWA.

F. PERSONAL REPRESENTATIVE INFORMATION – If you are signing this Authorization as the Insured's Personal Representative, please complete this section and attach a copy of the legal document establishing this authority (except for the parent of a minor, dependent child).

Name of Personal Representative: _____

Relationship to Insured:

☐Parent of dependent minor child (copy of legal document is not necessary)
☐Legal guardian or conservator *** ☐Health Care Power of Attorney ***
☐Executor or Administrator of Estate *** ☐Other: _____

*** Other than the parent of a dependent minor child, all other Personal Representatives must attach proof of their legal authority to this Authorization, unless these legal papers are already on file at MWA.