Authorization to Share Personal Information

You can use this form to give permission to Indiana University Health Plans to share your personal health information with a trusted person or organization you select. Please complete and sign this form.

How long does this permission last? Permission to share your records ends on your last day as a member of the plan or when you write to us and tell us to end it.

Can I change my mind and "take back" this permission? You can tell us to stop sharing your information in the future.

How do I end permission to share my personal health information? You will need to write to us to request an end to your permission. Be sure to sign and date it. You can mail or fax your request. Please keep a copy for your records.

Member information (required)		
Member ID number:	Member date of birth (MM/DD/YYYY):	
Member first name:	Member last name:	Middle initial:
Member permanent address:		
City:	State:	ZIP code:
If your permanent address is outside of the plan's service area, you will lose your plan.		
Date at permanent address (MM/DD/YYYY):		
Daytime telephone number:	Evening telephone number:	
Email address (optional):		

Please note: This form does not give permission to the person or organization named to:

- Change the plan you are enrolled in, or
- Represent you in a claims appeal, or
- Decide what kind of care you get

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Who do you want to share your information with? (required)		
Name:		
Address (optional):		
City:	State:	ZIP code:

Your permission (required)	
Personal health information is protected by the Health Insurance Portability and Accountability Act (HIPAA). When you sign this form, you agree to the following: Indiana University Health Plans and its related companies have permission to give my personal health information to the person or organization listed in the section above. Records may contain information on specific medical care or services I received. They may also contain information created by others. The information may include medical, claim or benefit records.	
Signature:	Date (MM/DD/YYYY):
❏ Check here, and complete the Legal Representative Information section if you are signing as a legal representative. If the member can only sign with an "X," a witness will also need to sign the form. This witness can't be any person or organization receiving the member's personal health information.	
Witness signature:	Date (MM/DD/YYYY):

Legal representative information		
If the member can't sign this form, a legal representative may sign, complete and return this form for the member. A legal representative is someone who has the legal right to sign for the member. Please attach proof that you are the member's legal representative (for example, Power of Attorney). We can't accept this form without it.		
First name:	Last name:	Middle initial:
Address:		
City:	State:	ZIP code:
Telephone number:		

If you have any further questions, please call IU Health Plans at 800.455.9776 or 317.963.9700 or TTY (Relay Indiana) at 800.743.3333.

Send the completed form to:

IU Health Plans, Attn: Enrollment Department
950 N. Meridian St., Suite 400, Indianapolis, IN 46204-1202

Or fax to:
F 317.968.1331

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