Wabash Memorial Hospital Association
1501 North Water Street – Decatur, IL 62526
Customer Service (217) 429-5246 or 888-800-9161

Authorization For Release of Protected Health Information

I hereby authorize the use or disclosure of my individually identifiable protected health information as described below. I understand that this authorization is voluntary and not a condition of enrollment, eligibility for benefits or payment of claims. I understand that the released information may no longer be protected by federal privacy regulations if not released to a health plan or health care provider.

I may revoke this authorization at any time by notifying WMHA in writing. If I choose to revoke this authorization, it will have no affect on actions WMHA may have taken before they received my revocation.

Member Name_______________________________________**Phone (___)** _________________

Date of Birth_________/_________/_______________
MM DD YYYY

Street Address____

City, State, Zip ____

Specific description of information that may be released (including date(s). If you need more space, you may use the back of this form or include additional dated and initialed pages.

____ Dues / payment information
____ Copies of claims
____ Explanation of benefits, payments or denials
____ Medical records (WMHA Clinic only)
____ Other_________________________
Describe specific information

Release my protected health information to the following person(s) and or legal representative:

_______________________________________ _____________________________________
(Print full name) (Title or relationship to member)

_______________________________________ _____________________________________
(Print full name) (Title or relationship to member)

_______________________________________ _____________________________________
(Print full name) (Title or relationship to member)

This authorization will expire on ________/________/________or on the occurrence of the
MM DD YYYY
following event: ____

_______________________________________ _____________________________________
Signature of member or member's legal representative Date