EASTERN MICHIGAN UNIVERSITY
HEALTH BENEFIT PLAN
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I, ____, give authorization to EMU Health Benefit Plan representatives to disclose Health Information about me to the following persons when they call on my behalf to discuss EOB or other benefit or payment issues. Health Information includes any information relating to my medical, dental, vision, or prescription drug benefits, such as a claim submitted by a provider for payment for medical treatment that I received.

Name	Relationship
Name	Relationship
Name	Relationship

I understand my Health Information may contain information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral or mental health services, hepatitis, tuberculosis, and treatment for alcohol and drug abuse.

This authorization will expire when I am no longer a member of the EMU Health Benefit Plan or on the following date ______________________.

I understand I have the right to revoke this Authorization at any time, except to the extent that it has already been relied upon. I understand that if I decide to revoke this authorization, I must send written notice of my decision to: Eastern Michigan University Health Benefit Plan, Attn: Privacy Officer, Benefits Office, 140 McKenny Hall, Ypsilanti, MI 48197.

I understand my Health Information disclosed pursuant to this Authorization may be subject to redisclosure by the recipient.

I understand I am not required to complete this form to receive health benefits or to be enrolled in any health benefit plan or program.

If signed by Individual:

Signature: ____________________________

Printed Name: _________________________

Date Signed: __________________________

If signed by Personal Representative:

Signature: ____________________________

Printed Name: _________________________

Relationship: __________________________

Date Signed: __________________________