



Destiny Health Insurance Company
AUTHORIZATION FOR RELEASE OF PROTECTED
HEALTH INFORMATION (PHI)

Member's last name, first name, middle initial
Social Security Number
Dependent's last name, first name, middle initial (if 18yrs or older)
Dependent's Social Security Number
Street number and street name
Apt. No.
City
State
Zip code
Area code/home phone number
Area code/work phone number
E-mail address

1. I authorize Destiny Health Insurance Company ("Destiny Health") or its authorized representatives to release my PHI as described below. This authorization does not apply to psychotherapy notes.
2. I understand that my PHI will be used and/or disclosed by Destiny Health for the following purpose:

At my request
To resolve my claims issue
Other (describe):

3. The person or organization that will receive my PHI is:

Name
Area code/ phone number
Street number and street name
Area code/FAX phone number
City, State, Zip Code
E-mail address

4. I authorize the release of the following PHI (check one):

All health information related to the provision and payment for my Destiny Health benefits and health services.
The claim for my service on ___/___/___ (MM/DD/YY)
The following information (describe):

NOTE: You must give specific permission to release the following information even if you checked a box above. Please authorize the disclosure of all that apply with your initials.
Genetic Information HIV / AIDS Mental Health Substance/Alcohol Abuse

5. I understand that this authorization will expire on(complete one):

This date ___/___/___
Upon resolution of my claims issue
When I revoke this authorization
The date Destiny Health fulfills this request
The happening of this event (describe):

6. I understand the information disclosed in connection with this authorization may be redisclosed and no longer protected by federal privacy regulations.

7. I release Destiny Health Insurance Company, its employees and representatives from all liability arising from this disclosure of my PHI.

8. I understand that I may revoke this authorization at any time by notifying Destiny Health in writing, knowing that previously used and/or disclosed information will not be subject to my request to revoke.

9. I understand that my authorization is voluntary and is not a condition of enrollment under Destiny Health, payment of claims, or eligibility for benefits.

Signature of Member or his or her Authorized Representative
Date
Printed name of Member's Authorized Representative
Relationship to the Member