DELAWARE VALLEY HEALTH TRUST

Authorization for Release of Personal Health Information

I, _____ (the "Individual"), whose birth date is _____
[Print Name] *[MMDD/YYYY]*
authorize the use or disclosure of my protected health information ("PHI") as described below.

1. Party or parties authorized to disclose my PHI:

_____

[List each individual and/or organization that you authorize to disclose your PHI.]

2. Party or parties authorized to receive my PHI:

_____

[List each individual and/or organization that you want to receive your PHI. Only parties listed here will receive your PHI.]

3. Specific description of the PHI that you want disclosed:

_____

_____

[Provide a detailed description of the PHI that you want disclosed. For example, if you want help with the adjudication, payment or denial of a claim or an appeal, please include information about the type of claim/service and relevant dates.]

4. Purpose of the disclosure:

_____

_____

[Describe why you want your PHI disclosed. For example, if you want help with the adjudication of a claim, you can write "I want help with the adjudication of a claim" or if you want to share your PHI with a spouse, significant other or member of your employer's HR staff, you can write "I want to share my PHI with {Insert Person}". If you would rather not say why you are requesting the disclosure, please write "At the request of the Individual" in this section.]

You may refuse to sign this authorization. The Delaware Valley Health Trust will not condition treatment, payment, enrollment or eligibility for benefits on your signing of this authorization. However, refusal to sign this authorization may prevent the party that you want to receive your PHI from acting on your behalf.

This authorization will expire either one (1) year from the date of your signature or upon final resolution of the matter for which the PHI is used or disclosed, whichever is later.

You may revoke this authorization at any time by notifying the party or parties named above in writing. This revocation will have no effect on actions taken or information provided before the receipt of the revocation.

PHI disclosed pursuant to this authorization may be re-disclosed by the recipient(s) without your permission and may no longer be protected by applicable privacy law. However, you have the right to seek assurances from such party that the PHI will not be re-disclosed.

_____ _____
Signature of Individual or Personal Representative Date

_____ _____
Printed Name of Individual or Personal Representative Email Address / Phone Number

_____
Description of Personal Representative's authority to act for Individual (if applicable)

Please return to dvhtclaims@dvtrusts.com

DELAWARE VALLEY TRUSTS
Managed Risk. Collective Rewards.

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