WebTPA
An AmWINS Group Company

P.O. Box 1808
Grapevine, TX 76099
FAX (469) 417-1960

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize the use and disclosure of my protected health information as described below.

My protected health information is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse and that relates to: (i) my past, present or future physical or mental health or condition; (ii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of health care to me.

I _____ _____**, (plan participant) authorize the following**
First Name Last Name

individual, or person(s) to receive my protected health information:

1. First Name: _____ Last Name: _____
   Date of Birth: _____ (mm/dd/yyyy) Relationship to health plan participant: _____ (Spouse, Parent, Child, Brother, Sister, etc…)

2. First Name: _____ Last Name: _____
   Date of Birth: _____ (mm/dd/yyyy) Relationship to health plan participant: _____ (Spouse, Parent, Child, Brother, Sister, etc…)

3. First Name: _____ Last Name: _____
   Date of Birth: _____ (mm/dd/yyyy) Relationship to health plan participant: _____ (Spouse, Parent, Child, Brother, Sister, etc…)

4. First Name: _____ Last Name: _____
   Date of Birth: _____ (mm/dd/yyyy) Relationship to health plan participant: _____ (Spouse, Parent, Child, Brother, Sister, etc…)

5. First Name: _____ Last Name: _____
   Date of Birth: _____ (mm/dd/yyyy) Relationship to health plan participant: _____ (Spouse, Parent, Child, Brother, Sister, etc…)

The protected health information that may be used and disclosed is as follows:

Personal Health Information relevant to that person's involvement in your care or payment related to your care.

I understand that I may revoke this authorization at any time by sending a written notification to WEBTPA, P.O. Box 99906, Grapevine, TX 76099, and this revocation will be effective for future uses and disclosures of protected health information. However, I further understand this revocation will not be effective for information that WEBTPA has already used or disclosed relying on this authorization.

This authorization expires upon receipt of a written notification to revoke the authorization.

Group Number: _____ (Look on Your ID Card) Member ID: _____ (Look on Your ID Card)

Plan Participant's Name: _____ (Print First Name) _____ (Print Last Name)

Signature of Plan Participant: _____ (Please Sign In Ink)

Please mail or fax this form to:

WEBTPA
P.O. BOX 1808
Grapevine, TX 76099
Attention: Customer Service Department
Fax # 469-417-1960