



AMERICAN MARITIME OFFICERS (AMO) PLANS

2 West Dixie Highway, Dania Beach, FL 33004
Tel: (954) 920-4247 (800) 348-6515 Fax: (954) 920-9482 www.amoplans.com



A UnitedHealthcare Company

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Protected Health Information (PHI) is information that is created, received, transmitted or stored by the AMO Medical Plan (the "Medical Plan.") Except as permitted by law, the Medical Plan may not use or disclose PHI to persons other than those you specify on this form. In order for the Medical Plan to disclose PHI to someone other than you, you must complete this authorization form and return it to the Medical Plan. You must have a separate authorization form for each person that will have access to your PHI. The Medical Plan may request that you complete this form where the use of disclosure of your PHI is necessary. In addition, you may submit this form to the Medical Plan to allow a third party access to your PHI. This form is not used if you are requesting your own PHI.

PART 1: REQUIRED INFORMATION

Participant's Name:	SSN: XXX-XX-	DOB:
Street Address:		
City:	State:	ZIP Code:

PART 2: AUTHORIZED PERSON

I hereby authorize the AMO Medical Plan to disclose the PHI identified in Part 3 of this form to the following person:

Name:	SSN: XXX-XX-	Relationship:
Street Address:		
City:	State:	ZIP Code:

PART 3: DESCRIPTION OF THE INFORMATION TO BE DISCLOSED

Please select from the following:	<input type="checkbox"/> All Claims Information
	<input type="checkbox"/> All Eligibility Information
	<input type="checkbox"/> Other Specific Issue _____ (please specify – i.e. dates of service, date of accident, ect.)

PART 4: VALIDITY OF AUTHORIZATION FORM

This Authorization is valid until I cancel the Authorization by completing and submitting a Cancellation of Authorization form or for specified dates.

From: _____ MM/DD/YYYY	Thru: _____ MM/DD/YYYY
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PART 5: ACKNOWLEDGEMENT AND SIGNATURE

I acknowledge and understand that I have the right to revoke this Authorization at any time by submitting a Cancellation of Authorization. I understand this Authorization is limited to the person specified in Part 2 of this form.

Participant Signature:	Date:
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* If you are signing as the Personal Representative of the person whose PHI is to be disclosed, you must enclose documented proof of your authority to act for that person (i.e. Power of Attorney, Letters of Guardianship.) Please note that the documentation must specifically include health care purposes. You may mail or fax the completed and signed Authorization to the Privacy Officer at the address listed above.

NOTARY PUBLIC

STATE OF _____)
COUNTY OF _____)

The foregoing instrument was acknowledged this _____ day of _____, 20____, by _____ (print name of participant), who personally appeared before me and acknowledged that he/she signed the instrument voluntarily for the purpose expressed in it.

Signature of Notary Public	NOTARY SEAL	<input type="checkbox"/> Personally Known
Print, Type, or Stamp Commissioned Name of Notary Public		<input type="checkbox"/> Produced Identification
Date Commission Expires		Type of Identification: _____