AMERICAN MARITIME OFFICERS (AMO) PLANS

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For AMO Official Use Only
Received Date: ________
Received By: __________

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) FOR THE MEDICAL CENTER PURPOSES

In order for the AMO Medical Center (the "Medical Center") to use or disclose Protected Health Information ("PHI") to someone other than you, you must complete this Authorization Form and return it to the Medical Center office. PHI is information that is created, received, transmitted or stored by the Medical Center, which relates to your past, present, or future physical or mental health, health care, or payment for health care, and either identifies you or provides a reasonable basis for identifying you. Except as permitted by law, the Medical Center may not use or disclose PHI to persons other than those you specify on this form. The Medical Center may request that you complete this form where the use of disclosure of PHI is necessary to carry out its functions. In addition you may submit this form to the Medical Center because you want someone to request your PHI from it. This form is not used if you are requesting your own PHI.

ALL OF THE SECTIONS MUST BE COMPLETED. PLEASE PRINT ALL INFORMATION

PART 1: REQUIRED INFORMATION	
Name:	SSN: XXX-XX-
I, ____, hereby authorize the AMO Medical Center to disclose the PHI identified in Part 2 of this form to the following person(s): (Please designate person(s) and provide their name and address.)	
☐	Spouse/ Partner:
☐	Business Agent:
☐	Attorney:
☐	Other Person (s):

PART 2: DESCRIPTION OF THE INFORMATION TO BE USED OR DISCLOSED	
I authorize the AMO Medical Center to disclose PHI (including written, electronic, or oral information) to the person (s) identified in Part 1 of this form in connection with the following (mark all that apply). Note: if you want different people to have access to different information, you must fill out a separate Authorization form for each person).	
☐	All treatment and services information (this selection will provide uninterrupted service to the authorized person(s)
☐	Specific treatment or service:
	Description of treatment or service:
	Date(s) of service:
☐	Other (please specify):

PART 3: PURPOSE OF THE USER OR DISCLOSURE	
The purpose(s) for which the person(s) named in Part 1 of this Authorization form may have access to my PHI is as follows (mark all that apply.)	
☐	Treatment/ health care decision making
☐	Payment for health care
☐	Health care claims or appeals
☐	Coordination of benefits
☐	Eligibility for benefits
☐	Preauthorization
☐	All of the above
☐	Other purpose/ activity (please specify):
☐	I am requesting disclosure of PHI for my own reasons

PART 4: VALIDITY OF AUTHORIZATION FORM	
This Authorization is valid for the following period checked, or until I cancel the Authorization by completing a Cancellation of Authorization form, whichever occurs first:	
☐	One year from date of signing (this selection will necessitate an updated Authorization at the end of the expiration period).
☐	More than one year, ending on _________________ (this selection will necessitate an updated Authorization at the end of the expiration period).
☐	Until the specific issue raise in Part 2 is resolved.
☐	Other event or time (please specify):

PART 5: ACKNOWLEDGEMENT AND SIGNATURE

I acknowledge and understand the following:

- I have the right to refuse to sign this Authorization. The AMO Medical Center will not condition treatment, payment, enrollment, or eligibility for health plan benefits on receipt of an Authorization.

- I have the right to revoke this Authorization at any time by submitting a Cancellation of Authorization form to:

  Privacy Officer
  AMO Medical Plan
  2 West Dixie Highway
  Dania Beach, FL 33004

- Revocation (Cancellation of Authorization) is only effective after it is received and logged by the AMO Medical Plan's Privacy Officer. I understand that any use or disclosure made prior to the revocation under this Authorization will not be affected by a revocation.

- I understand that after PHI is disclosed, it may no longer be protected under the Federal Privacy Regulations and the recipient of the PHI may disclose it again.

- I understand that I am entitled to receive a copy of this Authorization.

PART 6: SIGNATURES

Participant Signature: (or Signature of Personal Representative)	Date:

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.