Health Coverage Information Release Consent

I authorize the release of my health coverage information to the party listed below. This consent allows for the sharing of health coverage details as required.

Full Name:

Date of Birth:

Member ID / Policy Number:

Release Information To (Name/Organization):

Relationship to you (if applicable):

Purpose of Information Release:

I understand that this consent is voluntary and may be revoked by me at any time in writing.

Signature:

Date:

Submit