P. O. Box 947, Valdosta, GA 31603-0947
Phone 1-877-949-0940 Fax (229) 249-9840

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary and that I may refuse to sign this authorization. I understand that I may revoke it at any time by submitting my revocation in writing to TLC Benefit Solutions, Inc.

Individual's name: _____ Date of Birth: _____ Member ID#: _____

Telephone: _____

Persons/organizations authorized to provide the information:

_____

Persons/organizations authorized to receive the information:

Name: _____

Relationship to Member: _____

Specific description of information to be used or disclosed (including date(s)):

_____

_____

_____

OR check this box

☐ All information relating to my health care

Specific purpose of the disclosure:

_____

_____

This authorization will expire _____ (indicate date, or an event relating to you personally or to the purpose of the authorization).

I have read and understood the following statements about my rights:

- **I may revoke this authorization at any time prior to its expiration date by notifying the providing organization, in writing, but the revocation will not have any effect on any actions that the entity took before it received the revocation.**
- **I may see and copy the information described on this form if I ask for it.**
- **I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).**
- **The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity. I have the right to seek assurances from the above-named persons/organizations authorized to receive the information that they will not re-disclose the information to any other party without my further authorization.**

_____ _____

Signature of Individual or Individual's Representative Date
(Form MUST be completed before signing.)

Printed name of the Individual's Representative: _____

Relationship to the Individual, including authority for status as Representative: _____