



**NON MINOR DEPENDENT  
AUTHORIZATION TO RELEASE HEALTH INFORMATION**

Employee Name: \_\_\_\_\_  
Employee Group Number: \_\_\_\_\_  
Non-Minor Dependent's Name: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM / DD / YR

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Dependent's Telephone Number (where best to contact Dependent): \_\_\_\_\_

Dependent's Identification Number and/or Social Security Number: \_\_\_\_\_

Parties Authorized to  
Receive/Use Dependent's  
Health Information: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YR  
\_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YR

- By signing this authorization form I authorize Morris Associates to use and/or disclose my health information (information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996), to the individual(s) named above. I understand that I am under no obligation to sign this form, and that neither Morris Associates nor my health plan may condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.

I have signed this form voluntarily to document my wishes regarding the use and/or disclosure of the health information described below in Section 1 of this form.

1. Description of Health Information I Authorize to be Used or Disclosed.

The following is a specific description of the health information I authorize be used and/or disclosed: All health information pertaining to me that is in the possession of Morris Associates on behalf of my health plan.

2. Persons/Organizations Authorized to Use and/or Disclose My Health Information.

I authorize the following person(s) and/or organization(s), including my Health Plan, to use and/or disclose the health information described above in Section 1 of this form: MORRIS ASSOCIATES

3. Persons/Organizations Authorized to Receive and/or Use My Health Information

I hereby authorize the individual(s) specifically identified above to receive my health information from Morris Associates and my health plan for the purposes listed below in Section 4 of this form. I understand that the named individual(s) is/are not Covered Entities subject to federal privacy standards, and that the health information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards and that the above-named individuals may redisclose my health information without obtaining my authorization.

4. Description of Each Purpose for the Requested Use and/or Disclosure

At my request, I authorize my health information to be used and/or disclosed to the above-named individuals for any purpose.

5. Your Rights with Respect to This Authorization

5.1 Right to Revoke. I understand that I have the right to revoke this authorization at any time. I also understand that my revocation of this authorization must be in writing. To obtain a copy of an authorization revocation form I may contact my Plan Administrator at the address and telephone number contained in my Summary Plan Description. I am aware that my revocation will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) identified in Sections 2 and 3 of this form have already made in reliance upon this authorization.

5.2 Right to Receive Copy of This Authorization. I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of it.

6. Expiration of Authorization. This authorization shall be valid as long as the undersigned is covered under the health plan.

**TO BE COMPLETED BY DEPENDENT:**

I, \_\_\_\_\_ (please print name), have had an opportunity to review and understand the contents of this form. By signing this form, I am confirming that it accurately reflects my wishes.

\_\_\_\_\_  
Dependent's Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date