



**AUTHORIZATION TO RELEASE HEALTH INFORMATION
BETWEEN EMPLOYEE AND SPOUSE**

Employee's Name: _____

Birth Date: ____/____/____
MM / DD / YR

Spouse's Name: _____

Birth Date: ____/____/____
MM / DD / YR

Address: _____

Home Telephone Number: _____

Employee's Work Telephone Number: _____

Employee's Identification Number and/or Social Security Number: _____

Spouse's Identification Number and/or Social Security Number: _____

- 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 my spouse 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 my spouse (as 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 my spouse is not a health care provider, health plan or health care clearinghouse 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 my spouse may redisclose my health information without obtaining my authorization.

