Standard Authorization for Disclosure of Health Information (pf-3000)

I hereby authorize **BENEFIT ADMINISTRATORS, INC. (BAI)** to release/disclose the following Information for:

Patient Identification #	Patient/Participant Name	Patient Phone #
_____	_____	_____

Street Address	City	State	Zip Code
_____			

Information checked off below may be disclosed to:

Name of Person/Organization	Name of Person/Organization
_____	_____

The records to be disclosed cover the following period(s):

From (date - month - day - year)	To (date - month - day - year)
_____	_____
From (date - month - day - year)	To (date - month - day - year)
_____	_____

Check if this authorization is for psychotherapy notes. ☐

[If this authorization is for psychotherapy notes, you must not use it as an authorization for any other type of protected health information.]

Information to be disclosed (Please check only that which applies.):

Designated Record Set: (Please check only that which applies.)

- ❑ Enrollment Information
- ❑ Claims Information
- ❑ Payment Information
- ❑ Managed Care Information (Precertification, 2nd Opinions, Treatment Plans, Care Coordination, Case Management, etc.)

And / or

- ❑ Pharmaceutical information
- ❑ Consultation reports
- ❑ X-ray reports
- ❑ Discharge summary
- ❑ Progress notes
- ❑ Explanation of Benefits
- ❑ History and physical examination
- ❑ Laboratory tests
- ❑ Complete health record(s)
- ❑ Other (please specify) _____

I understand that this will include information relating to (check if applicable):

- ❑ Acquired Immunodeficiency Syndrome (AIDS) or infection with Human Immunodeficiency Virus (HIV)
- ❑ Mental health care
- ❑ Sexually transmitted disease
- ❑ Treatment for alcohol and/or drug abuse
- ❑ Other (please specify):

Authorizing Patient Signature	Date (month – day – year)
_____	_____

The patient may revoke this Authorization at any time in the future in writing to:
Benefit Administrators, Inc., 1250 Tower Lane, Erie, PA 16505