DMBA

150 Social Hall Avenue, Suite 170
P.O. Box 45530 • Salt Lake City, Utah 84145
Telephone: 801-578-5600 • Toll free: 800-777-3622
Fax: 801-578-5933 • Website: www.dmba.com

AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

PARTICIPANT INFORMATION (REQUIRED)

I, _____, authorize Deseret Mutual Benefit Administrators (DMBA), its business associates, and any and all healthcare providers and/or facilities (including mental health professionals) who have treated me before or after this authorization to use and disclose my PHI to the person/group named below:

1. Full name: _____ Birth date: _____

2. Full name: _____ Birth date: _____

3. Full name: _____ Birth date: _____

PHI is information about a person's past, present, or future physical or mental health that is individually identifiable and is maintained or transmitted by a healthcare provider, health plan, or healthcare clearinghouse. This generally includes, but is not limited to, information such as medical records, symptoms, diagnoses, treatments, prognosis, lab results, medications and information about insurance, claims, and payment.

Please note, disclosure of psychotherapy notes require a separate authorization.

Duration/Revocation: This authorization is valid until six months after termination of my enrollment in a DMBA-administered health plan unless revoked in writing before that time. I may revoke this authorization by writing to:

DMBA
Attn: Member Services
P.O. Box 45530
Salt Lake City, UT 84145

(Revocation becomes effective only after it is received by DMBA and the revocation will not apply to use and/or disclosure of PHI that occurs before the written revocation request is received by DMBA.)

I certify the above information is true and complete. I have a right to receive a copy of this authorization. Any information used or disclosed pursuant to this authorization may be subject to redisclosure and may, therefore, no longer be protected by privacy regulations. Treatment, payment, enrollment, or eligibility for applicable health benefits will **not** be conditioned upon my providing this authorization unless otherwise required by law.

Full name: _____

Signature: _____ Date: _____

Birth date: _____ DMBA ID number: _____

PERSONAL REPRESENTATIVES

If this authorization is signed by a person acting on your behalf, **he/she must attach documentation demonstrating authority to act on your behalf** (e.g., power of attorney, guardianship, conservatorship, etc.)

Personal representative: _____ Relationship: _____

Signature: _____ Date: _____

Please return completed form to DMBA, Attention: Member Services, P.O. Box 45530, Salt Lake City, Utah 84145