Authorization to Disclose Medical Information & Expenses

I, _____ , hereby authorize Liberty HealthShare to disclose my Protected Health Information & medical expenses to the following person(s):

Name of Individual(s)	Relationship to Member	Phone Number

This authorization is initiated at my request. The duration of this authorization is indefinite, unless otherwise revoked in a signed writing by me. I understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization. I understand that once any information is disclosed pursuant to the terms of this document the information may be subject to redisclosure by the recipient, and no longer be protected by the Health Insurance Portability and Accountability Act of 1996, as amended. I understand that requests for medical information and medical expenses from persons not listed above will require a specific authorization prior to such disclosure.

Signature of the member giving permission Date