

**Guide for Completing the
“Authorization To Release Protected Health Information”**

Section 1:

- **Patient Name:** Provide the name of the individual whose health information will be disclosed.
- **Member ID Number:** Provide the Member ID # or Participant ID # of the health plan cardholder.
- **Group Name:** Provide the name of the cardholder’s group or employer.
- **Group #:** Provide the group number that is listed on the identification card.
- **Person/Organization Requesting Information:** Provide the name of the organization or individual to whom Midwest Security should release the health information.
- **Person/Organization Providing Information:** Indicate Midwest Security Insurance Companies.
- **Description of Protected Health Information Requested (including dates):** Indicate the type of health information, with the associated date(s), that Midwest Security should disclose to the indicated organization or individual. (For example: Claims and benefit information for 2002 – 2003.) Please be specific if you are only authorizing disclosure of information about a particular claim.
- **Description of Reason for Disclosure:** Provide the reason you want Midwest Security to disclose the health information to the indicated organization or individual.

Section 2:

- Please note that the authorization for disclosure will expire one year from the date on the form. The signature of the Patient or the Patient’s Authorized Representative is required on the form, as well as the current date.