# Authorization for online access of family members' health information

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SANFORD HEALTH PLAN

Due to HIPPA privacy rules, you are not able to view online claims information for your spouse or dependent over age 18 without written consent. You can give your authorization by completing this form. Please return the completed form to Member Services via email, fax or mail. The contact information is provided above.

Member name_____ Date of birth _____/_____/_____

ID #_____

Member address_____
Street/PO Box Apt # City State Zip

1. As a dependent under a Sanford Health Plan policy, I hereby authorize the person named below to access my health information online through Sanford Health Plan's myHealthPlan, in writing or through verbal communication with Sanford Health Plan representatives. My health information will be accessible to the individual(s) listed below including my medical and prescription drug claims information, providers and dates of service. I understand that this authorization is voluntary. Unless allowed by law, this form will have no effect on my eligibility or benefits, nor does it affect my ability to obtain treatment or receive payment. Person allowed to access my information is:

   _____
   Name of person authorized to access health information Relationship to member

2. I understand that I may revoke this authorization at any time by written notification. However, the revocation is not valid if:
   - Action was previously taken in reliance on this authorization; or
   - This authorization is obtained as a condition for obtaining insurance coverage; other law provides the insurer with the right to contest a claim under the policy or the policy itself.

3. This authorization expires:

   __ The following date ____ / ____ / ____

   __ When the following event occurs: _____

   __ No expiration

Signature of member *(or personal representative)* Date

Name of personal representative *(if applicable)* Relationship to member Witness/organization representative