DIVERSE TECHNICAL LINES, INC.

2 RED BARN MALL • 120 S. YORK ROAD • HATBORO, PA 19040 • (215) 674-9400 • (800) 734-9400 • Fax (215) 674-0400

Authorization to Release Protected Health Information

Member Information: (individual whose information will be released)

Name			Date of Birth
Address			Telephone
City	State	Zip	Member ID #

Explanation of Authorization:

I understand that DTL, Inc. may use Protected Health Information (PHI), as more fully described in the Notice of Privacy, for some or all of the following purposes: enrollment in a health plan, termination of enrollment; processing, completion and/or submission of claim forms; completion, review or processing of application forms; billing and answering member questions relative to various aspects of a claim or plan. This list is by way of example, and is not deemed inclusive of all times when DTL, Inc., may use or disclose PHI.

I understand that I have the right to restrict or revoke the use or disclosure of my PHI for other uses or purposes. I further understand that I have the right to request restrictions as to how my health information may be used or disclosed.

This authorization will remain in effect until such time as I revoke it in writing.

Please check all boxes that apply:

- ☐ **I hereby authorize DTL, Inc. to release and/or receive PHI to/from medical providers (such as doctors, hospitals, pharmacies), insurance carriers, etc. for the provision of and payment for my health care benefits or services.**
- ☐ **I hereby authorize DTL, Inc. to release and/or receive PHI as stated above to/from my Group Contact.**
- ☐ **I hereby authorize DTL, Inc. to release and/or receive PHI as stated above to/from anyone identifying themselves as my spouse, my child, or my parent.**

If you choose to restrict the above authorizations as to whom or what may be released, please notify us in writing on a separate piece of paper and attach it to this form. Please sign and date this paper.

State law requires that you give specific permission to release the information below even if you checked any boxes above. Indicate your permission for DTL, Inc. to release and/or receive any of the following information by initialing all that apply:

Genetic Information	_____ (initials)	HIV/AIDS	_____ (initials)
Substance/Alcohol Abuse	_____ (initials)	Mental/Behavioral Health	_____ (initials)

By signing below, I authorize the use of my Protected Health Information by DTL, Inc.

Member Signature (age 18 & over)

Signature of Member
Date

Personal Representative (including Parent or Guardian)*

Printed Name of Personal Representative	Date
Signature of Personal Representative	Relationship/Authority

* If signing on behalf of someone other than yourself, are you the legal guardian, custodian, or have Power of Attorney for this member? ☐ Yes ☐ No