SUBSCRIBER'S AUTHORIZATION FOR SPOUSE REQUEST FORM

This Authorization form is intended for use by the Subscriber only to give unrestricted authorization to his or her spouse only. For limited authorization and any other type of authorization, use the Member's Authorization Request Form.

You may give your Health Plan and ACS Benefit Services, LLC (ACS) written authorization to disclose your Protected Health Information (PHI) to anyone that you designate and for any purpose. If you wish to authorize your spouse to receive your PHI, please complete the information below. **Completion of this form will not change the way ACS communicates with Members, including Subscribers. For example, ACS will still send explanation of benefits (EOB) statements to the Subscriber.**

Subscriber's Name_____ Subscriber's Date of Birth_____/_____/_____
(The Covered Employee) Month Day Year

Subscriber's ID Number_____ *(This is the number on your ID card)*

At my request, I authorize my Health Plan and ACS to disclose my Protected Health Information to my spouse: (enter name of spouse).

_____
(Name) (Address)

Please provide the following information to your spouse so that we may verify his/her identity and authority to receive your PHI: *Your Subscriber's ID Number, Subscriber Date of Birth, and Subscriber Address.*

NOTE: This information must be the same as the information ACS has on file from the Employer's Health Plan.

I authorize my spouse listed above to receive from representatives of my Health Plan and ACS any PHI about me that my spouse requests.

I would like this Authorization to expire on (enter date):_____/____/____.
If no expiration date is provided, this authorization will expire when revoked by me in writing.

I UNDERSTAND:

- **that I may revoke this Authorization at any time by giving the Group Health Plan written notice. However, if I revoke this Authorization, I also understand that the revocation will not affect any action the Group Health Plan or ACS took in reliance on this Authorization before the Group Health Plan or ACS received and processed my written notice of revocation.**
- **that the authorized person can receive PHI for any time prior to and subsequent to the effective date of this Authorization, unless this Authorization specifically limits any date or dates.**
- **that the Group Health Plan will not condition the provision of health plan benefits on this Authorization.**
- **the potential for information disclosed pursuant to this Authorization to be further re-disclosed by my spouse, and that this information may no longer be protected by the Health Insurance Portability and Accountability Act ("HIPAA"), a federal health information privacy law.**

_____ _____
Signature of Subscriber Date

If signed by an individual other than the Subscriber:

Print your full name _____

Describe your authority to act for the Subscriber (e.g. power of attorney, court order, parent of minor child, etc.):

_____

You must attach the legal document naming you as the personal representative if you have not previously submitted it.

NOTE: The effective date of this Authorization will be no earlier than the date ACS enters this Authorization into its system, typically within five (5) business days following receipt by the ACS Privacy Office. If you would like this Authorization to become effective on a date later than the date ACS enters the Authorization into its system, please insert the date here: _____/_____/_____**.**
Month Day Year

RETURN THIS AUTHORIZATION TO THE PRIVACY OFFICIAL AT THE OFFICE OF THE EMPLOYER

Received by: _____ Date: _____
(Privacy Official – Employer's Office)

Employer's Name: _____