NueSynergy
CUSTOMER FOCUSED & TECHNOLOGY DRIVEN

Authorization for Release of Information

I hereby authorize NueSynergy to disclose my individually identifiable health information as described below to the person(s) identified below.

I understand that this authorization is voluntary and that I may revoke it any time by submitting my revocation in writing to NueSynergy.

Claimant Name:_____ Subscriber's SSN:_____

Date of Birth:_____ Address:_____

City/State:_____ Zip Code: _____

Provider Name:_____ Date(s) of Service:_____

Name of Employer coverage is through:_____

IMPORTANT INFORMATION ABOUT YOUR RIGHTS

I have read and understand the following statements about my rights:

- I understand that this authorization will expire on _____.
- I may revoke this authorization at any time by notifying NueSynergy in writing, but the revocation will not have any affect on any actions NueSynergy took at my request before the revocation is received.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form.
- The information that is used or disclosed pursuant to this authorization may be disclosed by NueSynergy in order to assist me with a claims, service or other issue concerning my group benefits based on the dates of service defined above.

PARTICIPANT AUTHORIZATION

Signature:_____ Date:_____

Printed Name:_____

PERSONS AUTHORIZED TO RECEIVE YOUR PERSONAL HEALTH INFORMATION

Name	Email	Relationship	Phone
Name	Email	Relationship	Phone
Name	Email	Relationship	Phone