



Oxford Health Plans®

CONSENT FORM

FOR RELEASE OF CONFIDENTIAL MEMBER INFORMATION

Member Authorization:

The undersigned hereby authorizes Oxford Health Plans to release any and all of my medical claims information and medical records (including, but not limited to, treatment for venereal disease, alcoholism and drug abuse, abortion, mental disorder or developmental disability, cancer, and HIV status), as described below, to

_____, of _____
(name of recipient listed below) (title) (company name)

to assist in resolving my claims issue(s). This authorization shall be effective immediately and shall (check one only):

_____ Remain in place until it is expressly revoked by me in writing.

_____ Remain in place until _____.
(date)

_____ Only apply to the claims I incurred on _____. *

* If multiple claims were incurred on this same date, please specify the provider/facility name:

_____.

Additionally, the undersigned hereby authorizes the recipient named herein to file an initial appeal and/or grievance on my behalf concerning any claim issue covered by this *Consent Form*.

(check one) Yes _____ No

Member's Signature

Printed Name

Member ID # or SS #

Date

Recipient's Acknowledgement and Indemnification:

I, the undersigned, hereby acknowledge the sensitivity of the medical information to be received from Oxford pursuant to the Member Authorization executed by _____ and understand my obligation to maintain the confidentiality of _____
(name of Member)

said information. Further, on behalf of _____, I agree to indemnify _____
(company name)

Oxford against any and all claims that may arise in connection with the disclosure of said information.

Recipient's Signature

Printed Name

Group Number

Date

Please contact an Oxford Dedicated Group Service Associate (DGSA) prior to submitting this *Consent Form* to Oxford. A DGSA will then indicate the mailing address or fax number to be used when submitting the *Consent Form*.