Individual Authorization Form

Purpose: This form is used for an individual to authorize Clearpoint to use and disclose the individual's protected health information (PHI) for the purpose(s) stated.

TO THE INDIVIDUAL: Please read the following and complete the information requested.

No Conditions: This authorization is voluntary. Your health plan enrollment or eligibility for benefits is not contingent on receiving this authorization. However, without this authorization, ClearPoint LLC may not be able to assist you with your issue or question.

Named Party Authorized to Use or Disclose PHI:	
Name 1: **Clearpoint, LLC**	Title: **Plan Business Associate**
Name 2: {Optional}	Title: ☐Employee ☐Spouse ☐HR ☐Other:

Authorization Time Limit:
Authorization is valid: ☐ Until resolution of the issue outlined below ☐ from _____ through _____ mm/dd/yy mm/dd/yy

Individual Information:		
Subscriber (Employee) Name:	Subscriber SSN:	Subscriber DOB:
Individual's Name (if different than subscriber):	Daytime Phone:	Email:
Address:	State, Zip Code:	Home Phone:
List covered members: *Underline patient name*		Patient DOB:

General Claim Information:	
Claim/Question is regarding: ☐Medical ☐Dental ☐Vision ☐Rx ☐Other:	
Medical Plan Type: ☐**HMO**, *managed care* ☐**PPO**, *no referral required* ☐**POS** *PCP referral required* ☐**Indemnity**	
Carrier involved in this issue:	**Coverage effective date:**
****If you have a copy of a billing statement from the Provider's office OR a copy of the Explanation of Benefits (EOB) from your Insurance Carrier, please fax that information, along with this form.****	

Claim Information Needed:

Date(s) of Service	Total Amount Billed	Provider of Service	Services performed (e.g., office visit, lab, x-rays, surgery, inpatient hospital stay, etc.)

Purpose: (Check all that apply)			
☐Verify Claims Status	☐Benefits & Eligibility Inquiry	☐Enrollment Inquiry	☐Psychotherapy Notes
☐ Other:			
Question Details:			

I understand that, by signing this form, I am confirming my authorization for the use and/or disclosure of my protected health information, as described in this form.

Individual's Signature: _____ Date:_____

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representatives name: _____ Date_____

Relationship to individual_____

Please provide this completed form via fax or mail with your signature to the Benefit Advocate team at ClearPoint

ClearPoint LLC - 214 East Galer, Suite 300 - Seattle, Washington 98102
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