

AUTHORIZATION FOR USE OR DISCLOSURE
OF MEDICAL INFORMATION

AUTHORIZATION

I hereby authorize Glass Financial Group and its representatives to obtain and discuss information pertaining to (name of insured)

_____.

This authorization is limited to the following information: (Please check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Claims/health history | <input type="checkbox"/> Prior Authorization/Pre-certification | |
| <input type="checkbox"/> Pharmacy | <input type="checkbox"/> Premium Billing | <input type="checkbox"/> Transition of Care |
| <input type="checkbox"/> All of the Above | | |

USES

Glass Financial Group may use the information authorized only for the following purposes:

SIGNATURE

Print Name: _____

Member Identification Number: _____

Signature: _____

Member Date of Birth _____

Date: _____