



5502 58TH STREET, SUITE 700
LUBBOCK, TEXAS 79414
(806) 794-0844
(806) 783-0895 – FAX

AUTHORIZATION TO RELEASE INFORMATION

To all physicians, hospitals, clinics, dispensaries, sanatoria, druggists, and all other agencies (including other insurance companies, BlueCross-BlueShield, etc.): You are authorized to permit R H Administrators, and/or it's representatives to obtain or view a copy of your records pertaining to the examination, treatment, history, prescriptions, and medical expenses of the patient below.

I hereby authorize the disclosure of health record information of:

Patient Name: _____ Date of Birth: _____
Address: _____
Telephone Number: _____ E-Mail: _____

*****This authorization is valid for 1 Year from the date signed.*****

I authorize the organization listed below access to Protected Health Information in order to process pended or denied claims. PHI received by this organization may include elements of my medical records and/or claims history. I understand that I may revoke this authorization at any time, unless action has already been taken in reliance on this authorization.

This information is to be disclosed to:

**R H Administrators, Inc.
5502 58th Street, Suite 700
Lubbock, Texas 79414
(806) 794-0844 Telephone Number
(806) 794-2727 Fax Number**

The information is to be disclosed for the following purposes:

_____ Resolution of a pended or denied claim.

_____ Other: _____

I understand that R H Administrators, Inc. may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization unless it requires my authorization for eligibility or enrollment determinations relates to me, or for its underwriting or risk rating determinations.

I understand that my health information may potentially be re-disclosed by the recipient identified in this authorization. Neither R H Administrators, Inc. nor my health plan is responsible for any such disclosures, and RHA's workforce is released from any legal responsibility or liability for disclosures made pursuant to this authorization.

Signature of Patient or Legal Representative

Date

Description of authority of Representative to act on behalf of patient: _____
