



Permission to Speak Form

This form is used to confirm the direction of an individual that Virginia Premier Health Plan, Inc. may use or disclose protected health information for a particular purpose.

Permission To Speak With Form	
Member's Section	
<small>Please indicate each member(s) whose account you'd like for us to use and/or disclose protected health information.</small>	
Name:	Name:
Date of Birth:	Date of Birth:
SS#:	SS#:
Medicaid ID#:	Medicaid ID#:
Address:	Address:
Permission to Speak with Section	
<small>The person(s) listed below has my permission to transact business on behalf of all of the individuals listed in the Member's Section of this form.</small>	
Name:	Name:
SS#:	SS#:
Phone #:	Phone #:
Organization:	Organization:
Relationship to Member(s):	Relationship to Member(s):
Address:	Address:
This section is to be completed by Member/Parent/Guardian/Personal Representative	
<small>My signature below indicates I have had full opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction to Virginia Premier Health Plan, Inc. I understand that, by signing this form, I am confirming my authorization that Virginia Premier Health Plan, Inc. may use and/or disclose to the persons and/or organizations named on this form the protected health information.</small>	
<p><u>Expiration and Revocation</u> Expiration: This authorization will expire (complete below): M On ____/____/____</p> <p><small>Disclaimer: If an expiration date is not indicated above, the authorization period shall be one (1) year from the signature date unless written notification is received from member to revoke at the address listed on the form.</small></p>	<p><u>Expiration and Revocation</u> M On occurrence of the following event: Right to Revoke: I understand that I may revoke this authorization at any time by given written notice of my revocation to the contact office listed below. I understand that revocation of this authorization will not affect any action you took in reliance on this authorization before you received my written notice of revocation. I understand that a description of my right to revoke this authorization and exceptions to my right to revoke this authorization is provided in VPHP's Notice of Privacy Practices.</p> <p style="text-align: center;"> Virginia Premier Health Plan, Inc. Attn: Member Services Manager/Supervisor P.O. Box 5307 Richmond, VA 23220-0307 (800) 727-7536 </p>
Member's Name (Please print clearly):	Date:
Member's Signature	Date:
Printed name of person completing this form:	Signed name of person completing this form:
Relationship to Member(s):	Date: