Zing HEALTH™ Member Authorization Form

THIS AUTHORIZATION FORM MUST BE COMPLETED IN FULL FOR IT TO BE VALID.

Please complete the following information exactly as it appears on your member identification (ID) card.

PLEASE MAKE A COPY OF THIS FORM FOR YOUR RECORDS.

Mail your signed authorization to:

Zing Health
225 W. Washington Street, Suite 450
Chicago, IL. 60606

If you need assistance completing the form, call the Customer Service number listed on your Member ID Card.

Section 1. Member Information			
Member Last Name:	Member First Name	Member Middle Name:	
Date of Birth:	Member ID#:		
Street Address:			
City:	State:	Zip Code:	Phone Number:

Section 2. Authorization		
I authorize the use or disclosure of my individually identifiable protected health information (PHI) described in Section 3 to the following person/entity. I understand that this authorization is voluntary and that I may revoke it at any time by submitting a completed Revocation of Authorization Form to Zing Health. Failure to answer all questions may result in this request being returned.		
Person/Organization:		Relationship:
Purpose:		Telephone Number:
Street Address:		
City:	State:	Zip Code:

Section 3. Description of PHI/SPHI to be Released - You may select one or more

	Dates of Services From:	To:
☐ Health Plan Benefit Information, including coverage information	_____	_____
☐ Claims Information, including diagnosis, treatment and payment information	_____	_____
☐ Service Determination information	_____	_____
☐ Premium Information	_____	_____
☐ Others	_____	_____

Sensitive Protected Health Information (SPHI)
The disclosure of certain Sensitive Protected health Information (SPHI) may require specific authorization under State Law. If you check "yes," you are authorizing Zing Health to release the SPHI listed below and, if applicable to your data release request, it will be included in the information you selected above in Section 3. If you check "no" or make no selection at all, SPHI will not be released. This authorization may not be used for the release of Psychotherapy Notes.

Human Immunodeficiency Virus (HIV) or HIV/Acquired Immune Deficiency Syndrome, ☐

Sexually transmitted or "communicable" diseases (includes hepatitis, as well as venereal diseases), ☐

Drug, alcohol or substance abuse, ☐

Mental health or development disabilities (including mental retardation or similar disabilities, for example, those attributable to cerebral palsy, autism or neurological dysfunctions), and ☐

Genetic testing. ☐

V. Expiration & Right to Revoke or Terminate the Authorization

Expiration: Select a date/event when authorization will expire. The authorization cannot be processed if this is left blank.

_____ One year from the date is signed

_____ Other (insert date or event): _____

You must select a date when this authorization will end. All valid authorizations must contain a specific expiration date or event; for example: "hospitalization end date", "rehabilitation end date", etc. In addition, Zing Health is providing information about the right to terminate an authorization at any time.

Right to Revoke/Terminate: You may end this authorization at any time by giving written notice to Zing Health at the address listed below. However, Zing Health is not liable for the release of PHI or SPHI before the authorization was terminated.

Section 5. Signature and Acceptance of Terms

I understand that this authorization is voluntary, and that Zing Health cannot condition my eligibility for benefits, treatment, enrollment or payment of claims on the signing of this authorization.

_____ _____ _____

Signature Relationship Date

Document must be signed by the person (member), the parent of a minor child or the person's authorized representative. If you are a parent signing on behalf of a minor child, please sign your name - not the child's name. This authorization will expire when the minor child turns 18 years of age, unless proof of legal guardianship is produced. If you are signing as a Personal Representative, Power of Attorney, Legal Guardian, Executor or Administrator, complete the following and provide copies of the appropriate Legal documents to support your authority to execute this Authorization. If these documents are already on file at Zing Health, you do not need to provide them again.

Authorized Representative's Name:		Relationship:
Authorized Representative's Address:		
City:	State:	Zip Code:
Authorized Representative's Area Code & Telephone:		