



Attn: Stephen Geri  
3463 Magic Drive, Suite 137  
San Antonio, TX 78229  
(210) 558-3377 or (800) 990-3427

**AUTHORIZATION TO DISCLOSE  
PROTECTED HEALTH INFORMATION**

Individual's Name \_\_\_\_\_  
Home Address \_\_\_\_\_  
Home Telephone \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Policy Number(s) \_\_\_\_\_

**MY HEALTH INFORMATION: The health information that is subject to this Authorization consists of:**

All Health Information about me created or received by DEBS/Employer, except the following:  
\_\_\_\_\_  
\_\_\_\_\_

Other: \_\_\_\_\_

**Authorization Disclosure:** I authorize DEBS/Employer to disclose my health information described above to:  
**Name ("Recipient")** \_\_\_\_\_  
**Address:** \_\_\_\_\_

**TERM:** This Authorization will remain in effect until:  
  
 I revoke it in writing  
 The \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

I authorize disclosure in the manner described above, and understand that:

- DEBS/Employer will not condition my enrollment or eligibility for insurance benefits on my provision of this Authorization.
- DEBS/Employer does not guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.
- I may revoke this Authorization in writing at any time.
- This Authorization will remain in effect until the Term of Authorization expires or I provide a written notice of revocation to DEBS/Employer at the address listed above. The revocation will be effective upon DEBS/Employer receipt of my written notice.

\_\_\_\_\_  
Signature of Individual

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness