P.O. Box 857
Lanham, MD 20703
marylandhealthconnection.gov

MARYLAND HEALTH BENEFIT EXCHANGE

RELEASE OF INFORMATION AUTHORIZATION FORM

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, _____ , hereby voluntarily authorize the disclosure of my Personally Identifiable Information related to my application for health insurance, Advanced Payment Tax Credits, Cost Reduction Sharing and/or other benefits provided to the Maryland Health Benefit Exchange.

Print Name of Individual

II. The information is to be disclosed by:	**And is to be provided to:**
NAME OF FACILITY	NAME OF PERSON/ORGANIZATION/FACILITY
ADDRESS	ADDRESS
CITY/STATE	CITY/STATE

III. The purpose or need for this disclosure is:

☐ Personal Use ☐ Attorney ☐ Disability ☐ Other *(Specify)*
☐ Insurance ☐ School ☐ ☐ Other *(Specify)*

IV. The information to be disclosed from my enrollment application(s): *(check appropriate box(es))*

☐ Only information related to *(specify)* _____

☐ Only the period of events from _____ to _____

☐ Other *(specify)* _____

☐ Entire Record

☐ Written correspondence generated by MHBE related to my application.

If you would like any following sensitive information not to be disclosed, please list:

_____

V. I understand that I may revoke this authorization in writing submitted at any time to the MHBE Custodian of Records, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or *expiration event* is stated.

_____
(Specify new date)

I understand that MHBE will not condition eligibility for cost saving reductions, APTC or other benefits on my providing this authorization. This authorization extends only to the records generated by MHBE and does not include records created by third parties. It is my responsibility to request records directly from the generating party.

I understand that information disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected under Maryland law and the Privacy Act of 1974 [5 USC 552a].

SIGNATURE OF INDIVIDUAL OR AUTHORIZED REPRESENTATIVE *(State relationship to individual)*	DATE
SIGNATURE OF WITNESS *(If signature of individual is a thumbprint or mark)*	DATE

This information is to be released for the purpose stated above and may not be used or re-disclosed by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a State agency under false pretenses shall be guilty of a misdemeanor. **The below information must be completed in its entirety in order for MHBE to release the requested information.**

NAME *(Last, First, MI)*	Last 5 digits of Record Holder's Social Security Number **OR** MHBE Personal Identification Number (PIN)
ADDRESS	DATE OF BIRTH (mm/dd/yyyy)
STREET	CITY, STATE, AND ZIP CODE