Authorization for Release of Information

Information about the Use or Disclosure

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary and that I may refuse to sign this authorization and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information.

Participant Last Name _____ First Name _____ Middle Initial ____

Employer Name _____

Persons authorized to receive the information on behalf of the participant:

1. Last Name _____ First Name _____ Middle Initial _____
   Relationship _____
2. Last Name _____ First Name _____ Middle Initial _____
   Relationship _____
3. Last Name _____ First Name _____ Middle Initial _____
   Relationship _____
4. Last Name _____ First Name _____ Middle Initial _____
   Relationship _____

Description of information authorized to be used or disclosed:

Purpose of the disclosure:

Important Information About Your Rights

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time by notifying the providing organization in writing, but the revocation will not have any effect on any actions that the entity took before it received the revocation.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive my health care benefits (enrollment, or payment)
- The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving entity.

Signature _____ Date _____
mm/dd/yyyy

Please upload this form to your Participant Portal online or using your mobile app. You may also email us at claims@zynera.com.

PLEASE USE YOUR EMAIL PROVIDER'S ENCRYPTION FEATURES TO SEND YOUR EMAIL SECURELY.