Release to Discuss Personal Health Information

Faculty, Staff, Retirees

Effective Date: ____________________ Cancellation Date: __________________

Employee Information:

Name (Please Print) | Social Security Number | Banner ID Number

Date of Birth

Contact Information:

Street | City | ST | Zip

Home Phone | Work Phone

Patient Information:

Name (Please Print) | Social Security Number | Banner ID Number

Claim Regarding:

☐ Medical/Prescription ☐ Dental ☐ Vision ☐ Life

Claim Information:

Claim Number	Date(s) of Services	Provider Name

I hereby grant the Human Resources staff of Truman State University to investigate the claim or claims listed above and to represent my concerns to the insurance company or companies involved. This agreement will terminate the sooner of the cancellation date listed above or at the resolution of the claim question.

Signature of Patient or Patient's Representative | Date