AUTHORIZATION FOR ONLINE ACCESS OF HEALTH INFORMATION

P.O. Box 91110
Sioux Falls, SD 57109
(605) 328-6800
1-800-752-5863
Fax: (605) 328-6812

Member Name____ Date of Birth _____/_____/_____

ID # ____

Member Address____
Street/PO Box Apt # City State Zip

1. As a dependent under a Sanford Health Plan policy, I hereby authorize the person named below to access my health information online through Sanford Health Plan's *myHealthPlan*. My health information will be accessible to the individual(s) listed below including my medical and prescription drug claims information, providers and dates of service. I understand that this authorization is voluntary. Unless allowed by law, this form will have no effect on my eligibility or benefits, nor does it affect my ability to obtain treatment or receive payment. Person allowed to access my information is:

   ____
   Name of Person Authorized to Access On-Line Health Information

2. I understand that I may revoke this authorization at any time by written notification. However, the revocation is not valid if:
   - Action was previously taken in reliance on this authorization; or
   - This authorization is obtained as a condition for obtaining insurance coverage; other law provides the insurer with the right to contest a claim under the policy or the policy itself.

3. This authorization expires:

   _______ The following date ____ / ____ / ____

   _______ When the following event occurs: ____

   _______ No expiration

____
Signature of Member *(or Personal Representative)* Date

____
Name of Personal Representative *(if applicable)* Relationship to Member Witness/Organization Representative