



# Gallagher Benefit Services, Inc.

## CONSENT FOR RELEASE OF MEDICAL/DENTAL INFORMATION

Employer Name: \_\_\_\_\_ Carrier Name: \_\_\_\_\_

Employee Name: \_\_\_\_\_ Employee ID: \_\_\_\_\_

Patient Name(s): \_\_\_\_\_

Address: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Phone Number: \_\_\_\_\_

I authorize - **Gallagher Benefit Services, 4000 Midlantic Drive, Suite 300, Mt. Laurel, NJ 08054** to release (a. copies of my medical/dental records / b. information regarding medical/dental care and claims processing) (Circle a or b) to:

(Name/Office and Address) \_\_\_\_\_

- A. I authorize release of information for insurance claim determination purposes.
- B. I authorize the above to inquire on my behalf regarding insurance claims and pre-authorizations purposes.
- C. I authorize release of my  
 Entire medical/dental record

Release of medical/dental claims/benefit information via phone call  
 -OR-  
 Medical/dental records for the specific treatment dates from \_\_\_\_\_ to \_\_\_\_\_

- D. I authorize release of the following portions of my medical/dental records:  
 (Write your initials beside each area to be included in release)
- |  |   |
|--|---|
| <input type="checkbox"/> Mental Health | <input type="checkbox"/> Substance Abuse      |
| <input type="checkbox"/> HIV / AIDS    | <input type="checkbox"/> Communicable Disease |

I understand that this authorization shall be in effect for 180 days following the date of signature. However, I understand that this authorization may be revoked at any time by giving oral or written notice to the medical/dental office. A photocopy of this authorization shall constitute a valid authorization. I understand that once my records have been released, the medical/dental office cannot retrieve them and have no control over the use of the already released copies.

**I hereby release Gallagher Benefit Services, its subsidiaries and affiliates, and my medical/dental office from any and all liability, which may arise as a result of my authorized release of these records.**

Should my case require review by a governing agency or another medical/dental professional actively involved in my care to make a final determination, it is with my consent that a copy of these records will be submitted to the agency or medical/dental professional for this review.

\_\_\_\_\_  
Patient (or legal representative) \_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Date

**NOTICE:** The information has been disclosed to you from records whose confidentiality has been protected by federal and state law. You are prohibited from making further disclosures of such information without specific consent of the person to whom such information pertains or as otherwise permitted by state law. A general authorization is NOT sufficient for this purpose.