



**I (the member or person acting for the member) agree to the following:**

- I may authorize the Plan to use or give out member records. When I give an approval, the Plan will give out member records to a person or company.
- I know that member records can't always be kept safe under privacy laws. I know a person or company that receives member records can give them out again.
- I may take back this authorization by submitting to the Plan a request in writing.
- I may not be allowed to take back an authorization in some cases. I can learn more about this in the Plan's Notice of Privacy Practices.
- This authorization will end in twelve (12) months from the date of signature.
- If I want this authorization to end before this date, I will tell the Plan. I will tell the Plan when I want it to end and the reason. Use the space below to explain:

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- I am entitled to receive a copy of this form.
- I have read and understand this form.

*The information authorized for release may include records, which may indicate the presence of a communicable or venereal disease, which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).*

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If member - Signature of Member

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Date

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If member -Print Member Name

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If not member - Signature of Legal Representative

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Date

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Print Name of Legal Representative

Please send this Privacy Authorization Form to:

**Delaware Physicians Care, Incorporated**

Attn: Privacy Officer

252 Chapman Road

Newark, DE 19702-5406

Call Delaware Physicians Care at 1-866-543-2167 with questions or comments.

Effective Date: 7/01/04