GROWMARK, INC. and [AGRILAND FS]
Authorization for Release of Protected Health Information

By signing this Authorization, you are authorizing all group health plans (medical, dental, vision, and/or medical flexible spending account (FSA)) in which you are enrolled (the "Plans") to disclose your protected health information ("PHI") to the third parties specified in this form. You should be aware that any released information may be re-disclosed by the recipient and loses the protection of the Federal Privacy Regulations. You are not required to complete this Authorization unless you desire or agree to such disclosure.

Your Information

Your Name: _____ DOB: _____ Address: _____

Authorized Third Parties

The following specific individual, organization, or class of persons is authorized to receive your PHI:
Name:_____ Relationship (*e.g., spouse*):_____

The individual, organization, or class of persons identified above is authorized to have any of your PHI used or disclosed for any purpose, for any of the Plans, unless you otherwise identify here any limitations on this Authorization *(e.g. may only disclose PHI for purposes of payment under the medical plan) (leave blank or indicate "N/A" if no such limitations)*:

_____

This Authorization will remain in effect for as long as you are enrolled in any of the Plans, unless you contact us to revoke this Authorization. *If you have identified your spouse as an authorized third party above, in the event of your divorce, this Authorization will be automatically revoked as of the date you notify GROWMARK, Inc. [and [AGRILAND FS] of your divorce.*

Acknowledgements

By signing this Authorization:

- You understand that you may revoke this Authorization at any time by sending a written notification to the applicable address listed below, and that such revocation will be effective for future uses and disclosures of your protected health information. However, you further understand that this revocation will not be effective: (i) for information that the Plans have already used or disclosed, relying on this Authorization, or (ii) if the Authorization was obtained as a condition for coverage under the Plans and therefore the Plans, by law, have a right to contest coverage.
- You understand that your ability to receive treatment, enroll in the Plan(s), or become eligible for benefits is not conditioned on your signing this Authorization.
- You understand that if the Plans request this Authorization for marketing purposes, you have authorized the Plans to receive payment, either directly or indirectly, as a result of the use and/or disclosure of your protected health information.
- You understand that the Plans must provide a signed copy of the Authorization to you.

Signature

Signature: _____

Date: _____

If this Authorization is not made by the individual who is the subject of the protected health information involved, please check the applicable box explaining your authority to act on behalf of that individual.

☑ Parent of a minor child ☑ Pursuant to a court order or guardianship* ☑ Pursuant to a power of attorney* ☐ Other_____

*Please attach a copy of supporting documentation.

Please return completed and signed form to:

AGRILAND FS
Nicole Mitchell
421 N 10th Street
Winterset, IA 50273