



Authorization to Receive and Discuss Health Information

I hereby authorize Windsor Health Plan, Inc., which sponsors the Windsor Rx Plan (PDP), to provide my protected health care information to the person(s) named below and to discuss the information with that person, for the purpose of assisting me in making decisions regarding my health care and the use of my health care benefits.

Print name(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This Authorization is effective as of the date signed and will continue to be effective until I provide written notice to Windsor Health Plan, Inc. that the Authorization has been terminated.

Member Signature: \_\_\_\_\_

Member ID number: \_\_\_\_\_

Please print name: \_\_\_\_\_

Date: \_\_\_\_\_