Authorization to Disclose Information

I, _____, hereby authorize **Brightpoint**, a local agency acting on behalf of CKF-IN, ("**Brightpoint**") to disclose and/or discuss certain information about me ("My Information") to the following recipient at the location indicated:

Agency Name: _____

☐ Address: _____
Phone Number: _____

☐ Address: _____
Phone Number: _____

My Information and Purpose of Disclosure
Brightpoint may disclose that I (or my parent or legal guardian) have met with a Brightpoint Navigator for help applying for health insurance benefits through Indiana Health Coverage Programs or a Health Insurance Marketplace plan. This information is being disclosed at my request.

Right to Revoke Authorization and Expiration

I understand that I have the right to revoke this authorization, except to the extent that **Brightpoint** has already disclosed My Information in reliance on this authorization. This authorization may be revoked by sending a written request for revocation to **Brightpoint** by mail: **PO Box 10570, Fort Wayne, IN 46853** or by email: **ckfmailbox@mybrightpoint.org.**

If I do not revoke this authorization through the process described above, this authorization will expire after six months from the date of my signature below.

My Information May Be Re-Disclosed

I understand that uses or disclosures of My Information pursuant to this authorization may be subject to re-disclosure by a person who receives My Information. I understand that this re-disclosure may or may not be protected by the applicable privacy laws.

This Authorization Is Optional

I understand that **Brightpoint** does not require me to authorize the disclosure of My Information. **Brightpoint** does not condition its services on whether I sign this authorization. However, I acknowledge that I have agreed to sign this authorization.

This Authorization Must be Signed and Dated
This authorization is effective when signed and dated by the individual named above.

Signature: _____ **Date:** _____

If individual is under 18 years of age:
Signature of Legal Representative: _____ **Date:** _____

If signed by a Legal Representative, indicate the relationship to the individual who is the subject of the disclosure:
☐ parent ☐ legal guardian ☐ other: _____

Reminder: A copy of this authorization must be provided to the individual who signed it.