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") as indicated by my selection below:

- ☐ **Brightpoint** may disclose and/or discuss My Information with the following individual(s) who are involved in helping me obtain or maintain insurance coverage:

  Name _____ Relationship _____
  Phone _____ Email _____

  Name _____ Relationship _____
  Phone _____ Email _____

- ☐ **Brightpoint** may disclose My Information to social services providers for purposes of community supports such as public benefits, transportation, housing, counseling, or employment services.

My Information

Brightpoint may disclose information about or related to my eligibility for health coverage under Indiana Health Coverage Programs or through the Marketplace and the current status of my application or enrollment with Indiana Health Coverage Programs.

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.**

This authorization will remain in effect unless and until I revoke the authorization through the process described above.

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 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.