Authorization for Release of Personal, Health and Benefit Information

Employee Name:_____ Employed by:_____

Address:_____ Last 4 of SSN:_____

Phone Number:_____ Email Address:_____

I request and authorize the Benefit Center to release my personal, health and benefit information to the personal representative identified below. I understand signing this authorization is not a requirement to participate in the sponsored benefit plans.

A. Information to be disclosed (check one box only):

□ All of my and my dependents' health and benefit information*

□ Only my health and benefit information*

□ Only my dependent's health information*

*This includes information related to medical, dental, vision, life, disability insurances; as well as flexible spending accounts and/or COBRA benefits.

□ Other (such as information pertaining to a specific issue): _____

_____

B. Disclosure is to be made to (name of personal representative, relationship to employee and address):

_____

_____

C. This authorization, for the release of the PHI checked and/or listed above, is valid for one (1) year after the date it is signed or upon completion of the use of the information for the purpose it was intended, unless an earlier expiration date is indicated here: _____.

I understand I may revoke this Authorization at any time but, I must do so in writing to PlanSource at the address listed below. The revocation of this Authorization will not be effective to the extent that Benefit Center has already disclosed the information. I understand I have the right to receive a copy of this Authorization. I understand that the person(s) to whom information is disclosed under this Authorization may possibly re-disclose the information to others without my knowledge or consent and therefore the privacy of my personal, health and benefit information may no longer be protected by law.

Employee Signature:_____ Date Signed:_____

Personal Representative Signature:_____ Date Signed:_____

Please mail this form to PlanSource
P.O. Box 160940, Altamonte Springs, FL 32714
Or email it to; hipaa@plansource.com


##24T00848##################