



AN ALERA GROUP COMPANY



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AUTHORIZATION TO SHARE MY PROTECTED HEALTH INFORMATION

RETURN FORM TO: customerservice@fbsflex.com OR Fax: 585-641-7500

Mail: 400 WillowBrook Office Park-Suite, Suite 400, Fairport NY 14450

Protecting your confidentiality is important to Relph Benefit Advisors and Flexible Benefits System, Inc. HIPAA laws protect how and when your health care and personal information can be shared. If you would like Relph Benefit Advisors and Flexible Benefits System, Inc. to share information about you with another party, please complete this form. This includes sharing information with a spouse, friend, or even a parent, if you are over the age of 18. Your submission of this completed and signed form, gives Relph Benefit Advisors and Flexible Benefits System, Inc., permission to share your health information with the people you authorize (in SECTION 3). Your authorization is completely voluntary.

Important Notes: State and federal laws require special protections for HIV/AIDS, mental health, alcohol or substance abuse, pregnancy, abortion, family planning, sexually transmitted diseases, and genetic testing. If you would like Relph Benefit Advisors and Flexible Benefits System, Inc. to only share information on specific protected diagnoses, please clearly state this below in the options regarding specific information.

Relph Benefit Advisors and Flexible Benefits System, Inc. will only release information about a minor regarding abortion, sexually transmitted diseases, or substance abuse, if the minor completes and submits this authorization—even to disclose this information to a parent.

SECTION 1: PERSON WHOSE INFORMATION IS TO BE RELEASED:

Name: _____ Date of Birth _____ / _____ / _____

Address: _____ Relation to Employee _____

City: _____ State: _____ Zip Code: _____

Employee/Plan Holder's Name: _____

Employee/Plan Holder's Employer: _____

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary and that I may revoke it at any time by submitting revocation in writing to the entity providing the information.

SECTION 2: THE HEALTH INFORMATION TO BE RELEASED:

- All Health Information** (allows another person to act on your behalf for questions or issues)
- Membership Information** (i.e. coverage information, enrollment dates, eligibility, address, dates of birth, etc.)
- Benefit Information** (i.e. benefits available, benefits used, contract limits, etc.)
- Medical Records** (i.e. physician or hospital records, case management, etc.)
- Claim Information** (i.e. coverage information, enrollment dates, eligibility, address, dates of birth, etc.)
- Other** (specify the information you are authorizing) _____

The following items must be specifically indicated in order to disclose this information with the person(s) appointed:

- HIV/AIDS related information and/or records
- Pregnancy, abortion &/or family planning information
- Mental health information and/or records
- Sexually transmitted disease information
- Drug/alcohol diagnosis &/or treatment information
- Genetic testing

SECTION 3: PERSON/s OR ORGANIZATION TO RECEIVE THIS INFORMATION:

1—Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Relationship: _____

2—Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Relationship: _____

SECTION 4: UNDERSTANDING YOUR RIGHTS:

The person(s)/organization noted above are authorized to receive my individually identifiable health information for the specific purpose of assisting with claims, membership and or benefit eligibility issues. This authorization shall be in force until Relph Benefit Advisors and Flexible Benefits System, Inc., no longer maintain the health information or until revoked by the undersigned in the manner described below OR until (insert applicable date) _____.

I may revoke this authorization at any time prior to its expiration date by notifying Relph Benefit Advisors and Flexible Benefits System, Inc., but the revocation will not have any effect on any actions the authorized entity/entities took before it received the revocation. I may see and copy the information described on this form if I ask for it. I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment). The information that is used or disclosed pursuant to this authorization may be disclosed by the receiving entity. I have the right to seek assurances from the above-named persons/organizations authorized to receive the information that they will not disclose the information to any other party.

The revocation should clearly state your intent to revoke this authorization and the effective date of revocation.

SECTION 5: SIGN AND DATE THIS FORM:

To give Relph Benefit Advisors and Flexible Benefits System, Inc. your permission to share your health information with the people/organization you have authorized, please sign, date and print on the lines below.

I, (please print name here) _____, have read and understand the contents of this authorization.

I understand my signature on this form authorizes the use, request, and release of my individually identifiable health information as described in this form.

I understand that I may cancel this authorization at any time with proper written notice as outlined above.

I understand that if the person(s) or organization I authorize to receive information is not subject to federal health information privacy laws, he/she may further disclose the information and may no longer be protected by those laws.

Signature: _____ **Date:** _____

Personal Representative's Name (please print): _____

Description of Authority (power of attorney, legal guardian, etc.): _____