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# Authorization For Release of Information

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## I. Information About the Use or Disclosure

I hereby authorize the use or disclosure of my individually identifiable health information, or any of my Section 152 tax dependents, as described below. I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information.

Employer: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Participant name: \_\_\_\_\_ Family member(s) covered by this authorization: \_\_\_\_\_

Persons/organizations authorized to provide the information: Benefits Design Group, Inc.

Persons/organizations authorized to receive the information: \_\_\_\_\_

Specific description of information to be used or disclosed (including date(s)): My personal health information related to payment of claims under the Medical Reimbursement Plan.

Specific purpose of the disclosure: Submission, processing and payment of claims for reimbursement under the Medical Reimbursement Plan.

Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? X No \_\_\_ Yes (If Yes, describe) \_\_\_\_\_

This authorization will expire upon the earlier of (1) termination of my enrollment in the Medical Reimbursement Plan or (2) I revoke this authorization in writing.

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## II. Important Information About Your Rights

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing, but the revocation will not have any affect on any actions the persons/organizations 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 (eligibility, enrollment, treatment, or payment).
- The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving persons/organizations. I have the right to seek assurances from the above-named persons/organizations authorized to receive the information that they will not redisclose the information to any other party without my further authorization.

**III. Authorized Signature** (Form must be complete before signing. Please keep a copy of this completed and signed form for your records prior to submission to Benefits Design Group, Inc. at the address below.)

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

Printed name of the authorized signer above: \_\_\_\_\_

Relationship of the authorized signer, including authority for status as representative: \_\_\_\_\_

\*YOU MAY REFUSE TO SIGN THIS AUTHORIZATION\*  
*You may not use this form to release information for treatment or payment  
except when the information to be released is psychotherapy notes or certain research information.*

**Benefits Design Group, Inc. P.O. Box 370 Onalaska, WI 54650  
800-342-8235 or 800-554-7213**

## **BENEFITS DESIGN GROUP, INC. (“BDG”) NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

### **How Your Health Information May Be Used or Disclosed**

The following categories describe the ways that Benefits Design Group, Inc., (“BDG”), as third party administrator of Medical Reimbursement FSA Plan or Health Reimbursement Arrangement HRA Plan (collectively the “Plan”) claims, may use and disclose your health information. For each category of uses and disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose information will fall within one of the categories.

**1. Plan Operation and Reimbursement Functions.** As third party administrator of the Plan, we may use or disclose health information about you required to determine eligibility for plan benefits and to facilitate payment for qualified medical expenses as that term is defined in Code § 213. For example, reimbursement functions may include reviewing claims for health, dental, and/or vision services or products (as applicable to your plan type), to determine whether a particular claim requires additional doctor’s verification, verification of tax dependent status, or determining whether a claim is covered under the applicable Plan.

**2. Required by Law, as part of a Regulatory or Legal Proceeding, for Law Enforcement.** We may use or disclose your health information when (i) required by federal, state or local law, such as an IRS audit; (ii) in response to a court or administrative order if you or your estate are involved in a legal dispute; or (iii) in response to a formal request by a law enforcement official such as a subpoena or warrant.

**3. Disclosures to Plan Sponsors.** We may disclose your health information to the sponsor of your group health plan for purposes of facilitating reimbursement of eligible expenses. In addition, medical information may be disclosed to the Plan Administrator solely for the purpose of administering benefits under the Plan.

### **When Your Health Information May Not Be Used or Disclosed**

Except as described in this Notice of Privacy Practices, we will not use or disclose your health information, without written authorization from you or your dependents. You or your dependents may complete and submit the “Authorization for Release of Information” form that permits us to discuss health information with someone other than the patient. If you do authorize us to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time. If you revoke your authorization, we will no longer be able to use or disclose health information about you for the reasons covered by your written authorization, though we will be unable to retract any disclosures we have already made with your permission.

### **Statement of Your Health Information Rights**

You have the following rights with respect to you PHI: to request restrictions on certain uses and disclosures of your health information; to receive your health information through a reasonable alternative means or at an alternative location; to request confidential communications; to inspect and copy health information about you that may be used to make decisions about your plan benefits; to request that we amend your health information we keep for the Plan that you believe is incorrect or incomplete; to receive a list or “accounting of disclosures” of your health information made by us, except that we do not have to account for disclosures made for purposes of payment functions or Plan operations, or made to you; to inspect and copy such information; to receive a paper copy of this Notice of Privacy Practices at any time. A request for “accounting of disclosures” must be made in writing and specify a time period of up to six years, and may not include periods before April 14, 2003. One list per 12-month period will be provided free of charge; however, we may charge you for additional lists. If you would like to request restrictions on uses and disclosures of your health information, you must submit your request in writing to the Plan Administrator, or us as third party administrator of Plan claims. We are not required to agree to your request.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact the Plan Administrator, or the Privacy Officer BDG.

### **Changes to this Notice of Privacy Practices**

We reserve the right to amend this Notice of Privacy Practices at any time in the future and to make the new Notice provisions effective for all health information that it maintains. We will promptly revise our Notice and distribute it to you whenever we make material changes to the Notice. Until such time, compliance with the current version of this Notice is required.

### **Complaints**

Complaints concerning this Notice of Privacy Practices or questions concerning the handling of your health information should be directed to the Plan Administrator, or the Privacy Officer for BDG. All complaints must be submitted in writing. You will not be penalized for filing a complaint. If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services.

**Effective Date of This Revised Notice: July 15, 2005**

If you would like an expanded version of this notice contact:

**Benefits Design Group, Inc. PO Box 370 Onalaska, Wisconsin 54650 1-800-554-7213 or 1-800-342-8235**