
Authorization For Release of Information

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? 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.

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