

AUTHORIZATION FORM RELEASE OF PERSONAL HEALTH INFORMATION



COMPLETE SECTION A:

Participant Name: _____

Address: _____ City, State and Zip _____

Code: _____

Employer: _____

Participant Date of Birth: ___/___/_____ Daytime Phone Number: () _____ - _____

Participant Social Security Number: _____ - _____ - _____

Name(s) of Member(s), If other than Participant (your Spouse and/or Dependent Children), about whom information may be used and/or disclosed:

B. Directions for Release This authorization applies in accordance with my directions as checked below. I authorize the Employee Reimbursement Center to release and/or use protected health information pertaining to the member(s) listed in Section A . I understand that the information to be disclosed and/or used may include enrollment information, eligibility information, premium(payment) information, claims records, claims status, according to my directions.

CHECK ALL THAT APPLY IN SECTION B. 1:

B.1. I authorize the disclosure and/or use of the following information:

- _____(a) any information related to claims and payments
- _____(b) my enrollment, eligibility and premium payment records
- _____(c) Other (describe information in detail):

CHECK ALL THAT APPLY IN SECTION B.2:

B.2. I authorize the disclosure and/or use for the following reason(s):

- _____(a) for review and questions of a claim
- _____(b) for review and questions of payments
- _____(c) for review and questions of my elections

READ SECTION C:

C. Right to Revoke:

I understand that I may revoke this Authorization at any time except to the extent that action has already been taken in reliance upon it. If I do not revoke it, this Authorization will expire one (1) year after the date on which the Authorization is signed. To revoke the Authorization, I understand I must contact MGIS in writing.

EMPLOYEE REIMBURSEMENT CENTER AUTHORIZATION FORM RELEASE OF FLEXIBLE SPENDING ACCOUNT INFORMATION

YOU AND A WITNESS MUST SIGN IN SECTION D:

D. Authorization and Signature: I authorize the release of my confidential protected health information, as described in my directions in Section B. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is covered by Florida law which prohibits redisclosure or other laws that limit the use and/or disclosure of my confidential protected health information. My treatment, payment, enrollment and eligibility are not conditioned on signing this authorization but the information authorized may be necessary for claim review and appeal purposes.

I, _____, have read the contents of this Authorization, and I confirm that the contents are consistent with my directions. I understand that by signing this form, I am authorizing the use and/or disclosure of my confidential protected health information.

Your Signature Date

Signature of Witness Date

COMPLETE SECTION E FOR A LEGAL/PERSONAL REPRESENTATIVE:

E. Legal Representative: If a Legal Representative (or Parent, Guardian, Conservator, or Authorized Representative) on behalf of the individual signs this authorization, complete the following:

Legal Representative's Name (PRINTED): _____

Legal Representative's Signature: _____

Date: _____ Daytime Phone Number: _____

1. If this authorization is being requested/signed by the Legal Representative, you must furnish a copy of the Power of Attorney or other relevant documents designating you as the representative of the member.
2. Please provide a copy of this form to your authorized representative so that they will be able to establish the validity of their request for your protected health information.

**WHEN COMPLETE, SIGN AND FAX TO 801-990-0212 OR MAIL TO
MGIS CLAIMS AT THE ADDRESS BELOW**

MGIS Claims • PO Box 16110 • Salt Lake City, Utah 84116-2401 • 1.866.937.3539 • Fax 866.969.4446

www.We-R-CDH.com