BENEFITHELP
Solutions

Authorization to Release Reimbursement Account Information to Family Members or Designated Individuals

I hereby authorize the use of 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 my revocation in writing to the entity providing the information. Any uses or disclosures already made with my permission cannot be taken back. I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected under federal law. Please complete a separate form for each individual covered under the plan who wants to share information. Information obtained or disclosed with this authorization will be limited to the minimum information needed to achieve the purpose.

Employee Name: _____ Member ID#: _____

Employer Name: _____

I authorize BenefitHelp Solutions to obtain and disclose my Protected Health Information to:

Name: _____ Relationship: _____

Address: _____ Phone Number: _____

For the following benefits: □ All Benefits □ Healthcare Account □ Dependent Care Account

□Transportation/Parking Account □ Health Reimbursement Account

For the purpose of:

□ Any and all information
□ Only eligibility information or balance information
□ Only claim status (received/paid/date). Detailed claim information and diagnosis will not be released.
□ Other: _____

This authorization shall be in force and in effect until the following date OR event:

Date: _____(not to exceed 24 months) / Event: _____

I have reviewed and I understand this Authorization:

Employee Signature: _____ Date: _____

– OR –

Individual's Representative: _____ Date: _____

Relationship to Employee: __ Parent __ Legal Guardian* __ Hold Power of Attorney*

*Please attach legal documentation of you are the legal guardian or Holder of Power of Attorney

All fields must be completed for this Authorization to be valid
Employee must be given a copy of the completed form

To revoke this Authorization, please send a written statement to:
BenefitHelp Solutions, Attn: Privacy Office, P.O. Box 67230 Portland, OR 97268-1230 or Fax: 503-765-3554
Customer Service Phone #: 503-219-3679 or 1-888-398-8057
www.benefithelpsolutions.com