Authorization to Release Protected Health Information to Family Members or Designated Individuals

BenefitHelp SOLUTIONS

2964 (11/23)

PLEASE PRINT CLEARLY

*** This information is mandatory.** Form processing may be delayed if fields with an asterisk are not filled out.

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.

Section 1 Member information

* Member Name	* Member ID Number
* Employer Name	

Section 2 Recipient information

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

* Name	* Relationship	* Phone number	
* Address	* City	* State	* Zip

* For the purpose of:

☐ For any and all information related to my enrollment, premium, payment option information

☐ Other (specify exactly what is to be shared and disclosed): _____

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

Date (not to exceed 24 months)	Event (not to exceed 24 months)

Section 4 Authorization

I have reviewed and I understand this Authorization. I acknowledge that this form may be electronically signed and I agree that the electronic signature(s) appearing on this document are the same as handwritten signatures for the purpose of validity, enforceability, and admissibility.

* Member signature	* Date

Or

* Member's Representative's signature	* Date
* Relationship to Member ☐ Parent ☐ Legal Guardian* ☐ Hold Power of Attorney*	

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

Member must be given a copy of the completed form

To revoke this Authorization, please send a written statement to:
BenefitHelp Solutions Attn: Privacy Office

COBRA/Retiree: PO Box 40548 Portland, OR 97240-0548 or Fax: 503-765-3453
Customer Service Phone: 503-765-3581 or 1-800-556-3137