# Authorized Representative/ HIPAA Form

46632790 (12/18)

BenefitHelp SOLUTIONS

**PLEASE PRINT CLEARLY**

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

This form is to document the designation of an Authorized Representative for a consumer. This form authorizes the release of medical information to the named representative(s). This authorization does not provide your Authorized Representative with any authority, either implied or direct, over any direct care decisions or account management. If you wish to set up a power of attorney or living will, please discuss this with your attorney. We will not conduct benefit payments, enrollment or eligibility for benefits on the execution of this form.

## Section 1 Account holder information

| * First name | M.I. | * Last name | * Date of birth _____ / _____ / _____ | * Social Security number |
|---|---|---|---|---|

| * Mailing address | * City | * State | * ZIP |
|---|---|---|---|
| * Physical address | * City | * State | * ZIP |

| * Email address | * Contact phone number |
|---|---|
| * Employer | |

## Section 2 Authorized Representative Information

| * Authorized representative name | * Last four digits of Social Security number |
|---|---|
| * Authorized representative name | * Last four digits of Social Security number |

## Section 3 Expiration & revocation and authorized use & disclosure

I understand that due to HIPAA and other privacy regulations, BenefitHelp Solutions will not disclose my personal health information to other parties without my written authorization or as permitted or required by law. For this reason, I authorize you to discuss and disclose my personal health information to the person(s) named above for the purpose of assisting with, or facilitating, the coordination or payment of my health benefits. I also understand that if my Authorized Representative is not a healthcare provider or another entity subject to federal or applicable state privacy laws, my personal health information may no longer be protected by those privacy laws, and my Authorized Representative may further disclose my personal health information without my authorization. I acknowledge that my authorization is voluntary.

I understand I have the right to revoke or end this authorization at any time. I understand that if I do not wish the person(s) named in Step 2 to remain my Authorized Representative, I must revoke this authorization in writing by giving written notice of my decision to BenefitHelp Solutions. I understand that my revocation of this authorization will not affect any action that you have taken, or any information that you have already released based upon this authorization before you actually receive my request to revoke it.

**Further, I understand this authorization will terminate 12 months from the date of signature below (no authorization limit to designate an Authorized Representative on an HSA).**

| * Consumer signature | * Date |
|---|---|

**Return the completed form to BenefitHelp Solutions**

**Mail:** BenefitHelp Solutions, P.O. Box 2823, Fargo, ND 58108 **Fax:** 855-778-9837

**Questions?** Contact BenefitHelp Solutions at 855-378-0197, Monday - Friday, 7:00 a.m. to 7:00 p.m. CST.