Authorization to release Protected Health Information

PLEASE PRINT CLEARLY

*** This information is mandatory.**

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.

* Participant first name	* Participant last name
* Participant employer	* BHS Identification number

I authorize BenefitHelp Solutions to share my Protected Health Information with:

* First name	* Last name
* Relationship	* Contact phone number
For the following information related to the account: ☐ All information	☐ Other: Please describe below

This authorization will be in effect for the shorter of 24 months or the dates listed below:

* Authorization start	* Authorization end

This authorization will be in effect for the shorter of 24 months or until the event listed below:

* Authorization event

I have reviewed and understand this authorization
(If a member's representative please include a legal documentation stating you are the legal guardian or holder of power of attorney)

* Participant's signature	* Signature date
X	

I understand that I have the right to refuse to sign this authorization. My refusal to sign this authorization will not affect my enrollment in the plan or eligibility. I have the right to revoke this authorization in writing at any time. If I revoke this authorization, the information described above will no longer be used or disclosed for the reasons covered by this written authorization. Any uses or disclosures already made with my permission cannot be taken back. To revoke this authorization, please send a written statement to: BenefitHelp Solutions. Attn: Privacy Office

FSA/HRA: P.O. Box 67230. Portland, OR 97268-1230 or Fax: 1-888-249-5058
COBRA/Retiree: P.O Box 40548. Portland, OR 97240-0548 or Fax: 1-888-393-2943

Ready to submit? Mail, fax, or email this form to BenefitHelp Solutions
Mail: BenefitHelp Solutions, P.O. Box 67230, Portland, OR 97268
Fax: 888-398-8057 **Email:** Claims@benefithelpsolutions.com
Questions? Contact BenefitHelp Solutions at 888-398-8057.