Authorization for Release of Protected Health Information

A. Member Information

Member Name	Member Date of Birth	Plan Name or Number

Street Address		

City	State	Zip

Phone Number	Alternate Phone Number
☐Landline ☐Cell Phone	☐Landline ☐Cell Phone

This Authorization is provided in accordance with the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Standards") issued under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA").

I, _____, am a participant in the above referenced Plan and hereby authorize the use or disclosure of my protected health information as described in this Authorization.

1. Specific person(s) organization authorized to provide the information.
   Employee Benefit Management Services, LLC (EBMS)

2. Specific person(s)/organization authorized to receive and use the information. To authorize a specific person, you **must include name, date of birth and relationship to the individual.**
   _____
   _____
   _____

3. Specific description of the information to be used and/or disclosed.
   _____
   (if left blank, any and all information will be released to the designated individual(s) on item 2)

☐ I authorize the above referenced individual online access to my protected health information through miBenefits*

* Online access may only be granted to individuals who have been covered on the policy.

B. Signature Required

I, _____, hereby understand the following:

1. Right to revoke: I understand that I have the right to revoke this Authorization at any time by notifying the Third Party Administrator, in writing, at the appropriate address stated below in section C. I understand that the revocation is only effective after it is received and logged by the Third Party Administrator. I understand that I cannot revoke this authorization to the extent that action has been taken in reliance of this authorization (for example, any use or disclosure made prior to the revocation under this Authorization will not be affected by the revocation).

2. I understand that, after the information that is the subject of this Authorization is used or disclosed, the Privacy Standards may not protect it and the recipient may redisclose it.

3. I understand that this Authorization is not required for the Plan to use or disclose this information for purposes of treatment, payment or health care operations, or if the user or disclosure is otherwise permitted by the Privacy Standards, and that any revocation of this Authorization will have no effect on such uses or disclosures.

4. I understand that I am entitled to receive a copy of this Authorization.

5. I understand that this Authorization will automatically renew at the beginning of each calendar year unless otherwise revoked pursuant to the provisions outlined in paragraph 1 above. I further understand that this Authorization will permanently expire when the Individual's coverage under the Plan terminates, or when the Individual has no further claims for which payment is requested under the Plan, whichever is later.

_____ _____

Date *Individual Signature*

If signed by a person other than yourself, please check the appropriate relationship. You are required to provide proof of authority.

☐Parent of a minor child ☐Legal guardian
☐Power of attorney ☐Personal representative of deceased member

Personal Representative Signature	Personal Representative Printed Name	Date

C. Finalize and Send

- Form must be fully completed
- Submit form via on of the following:
  - Scan and email to eligibility.general@ebms.com
  - Fax to: 406.652.5380
  - Mail to:
    EBMS
    P.O. Box 21367
    Billings, MT. 59104

This form satisfies all required elements of a valid authorization under the Health Insurance Portability and Accountability Act of 1996 (HIPAA)