EMPLOYMENT PARTNERS BENEFITS FUND
PARTICIPANT AUTHORIZATION FORM
ALLOWING COMMUNICATION/DISCLOSURE OF HEALTH INFORMATION

Participant Name: ________________________________ ID No. and/or Birth Date: ________________

By signing this authorization form I authorize the Employment Partners Benefits Fund and its business associates (collectively "my health plan") use and/or disclose my health informationdescribed below to person(s) and/or organization(s) described below in the manner described below.

1. Description of Health Information I Authorize to be Used or Disclosed. The following is a specific description of the health information I authorize the Covered Entity to disclose to persons or entities described on this form. (*If you want to limit your authorization to only apply in specific areas, such as: pharmaceutical information; x-rays; physical examinations; all claims or those relating to a particular incident; payment; or enrollment , you should specify that directive here and provide a meaningful description. For Example: I authorize my health plan to release my protected health information to my attorney, Mr. John Laws, as may be required in connection with a lawsuit relating to a motor vehicle accident which occurred on or about May 1, 2003.*)

☐ I authorize my health plan to make unlimited disclosure to the person/entity I identify herein.
☐ My authorization is limited to the following type of information: ________________________________

____

____

☐ This authorization is for psychotherapy notes. (An authorization relating to psychotherapy notes must be submitted separately.)

2. Persons/Organizations I hereby Authorize to Receive and/or Use My Health Information.

Name of Participant's designated representative: ________________________________
Address: ________________________________

____

Phone: ______________Fax: ________________

I authorize my health plan to disclose the health information described above in Section 1 of this form to the person(s) and/or organization(s) identified above for the purposes listed below in Section 3 of this form. I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses subject to federal privacy standards, there is the potential that health information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards and that such person(s) and/or organization(s) may redisclose my health information without obtaining my authorization.

3. Description of Each Purpose for the Requested Use and/or Disclosure. I authorize my health information to be used and/or disclosed for the following specific purposes: *(choose one)*

☐ Pursuant to the Participant's wishes. ☐ Other (please describe):

____

____

4. Expiration of Authorization. This authorization will expire):

☐ Until cancelled (*This option is presumed to apply unless you select another option below.*)

☐ On _____/_____ /_____, or
MM / DD / YR

☐ Upon the occurrence of the following event(s) related to my health care or to the purpose(s) for which I have authorized the use and/or disclosure of my health information described in Section 4 of this form:

____

____

5. **I Understand My Rights as Enumerated Below:**

I understand that I have the right to revoke this authorization at any time. I also understand that my revocation of this authorization must be in writing and must be appended to this original authorization form, or a copy. I am aware that my revocation will not be effective as to uses and/or disclosures of my health information that have already made in reliance upon this authorization.

I understand that if desired, a copy of this form will be returned to me by my health plan. ☐ Please send copy.

I understand that I am under no obligation to sign this form. The person(s) and/or organization(s) described below who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization, except as follows:

I understand that a health plan may condition enrollment in the health plan or eligibility for benefits on this authorization if I am not yet enrolled in the health plan, the purpose of this authorization is to allow the health plan to obtain the information it needs to make an eligibility, enrollment, underwriting or risk rating determination and psychotherapy notes are not requested. If I refuse to sign this authorization I may be denied enrollment in the health plan or eligibility for health care benefits.

6. **Signature(s):**

I, ____ (please print name), have had an opportunity to review and understand the contents of this form. By signing this form, I am confirming that it accurately reflects my wishes.

____ ____ / ____ / ____

Participant Signature Date

If signed by a personal representative, complete the following:

Name of personal representative: ____ (please print name)
Relationship to participant or nature of authority (e.g., spouse, companion, guardian, health care power of attorney, other statutory authorization): ______________________________ (Attach any documents, such as a Power of Attorney.)

____ ____/ ____ / ____

Signature of Personal Representative Date

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APPENDIX

CANCELLATION OF AUTHORIZATION

This ______ day of _______________ , 200____ , I hereby cancel this Authorization.

____

Signature

____

Print Name

(***This cancellation will not be effective until received by Health Plan.***)

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