Authorization for Disclosure of Protected Health Information

Please note you must complete all requested information. Return completed form to ProBenefits by mail to 2634 Reynolda Road, Winston Salem, NC 27106; by fax to 877.761.1850; or by email to Trust@ProBenefits.com. Please keep a signed copy for your records.

I. Individual Authorizing Use and/or Disclosure of Protected Health Information

Participant Name ____ Date of Birth ______________________

Address ____ Last 4 Digits of SSN ___________

Phone Number _____________________________ Email ____

Employer Name ____

II. Type of Information Authorized to Be Used and/or Disclosed and Purpose of Disclosure

I authorize ProBenefits to use or disclose:

☐ All of my protected health information including, but not limited to, account information (e.g., balances, plan details, claims, card transactions, and reimbursements) OR

☐ Only the following protected health information (e.g., information related to a specific claim number, or specific provider, or specific dates of service):

____

This HIPAA Authorization is made:

☐ At my request OR

☐ Only for the following purpose (state a reason for the disclosure):

____

III. Designated Recipient(s)

I authorize ProBenefits to use or disclose the protected health information described above to the following recipient(s):

____

Create a 4-Digit PIN: ____________ The designated recipient listed above must provide this PIN when contacting ProBenefits.

IV. Expiration and Revocation

This authorization will expire (select one):

☐ On _____________ (MM/DD/YY)

☐ On the occurrence of the following specific event (e.g., resolution of claim issue):

____

Note: If this item is left blank, the authorization will remain effective for 60 days after the date listed below.

Right to Revoke: I may revoke this authorization at any time prior to its expiration date by sending a written revocation notice to ProBenefits. The revocation will not have any effect on any actions that ProBenefits took before it received the revocation notice.

V. Important Information About Your Rights

I understand that:

- This authorization is voluntary and I may refuse to sign it.
- I am not required to sign this authorization as a condition to receiving treatment or payment for health care; enrolling in a health plan; or establishing eligibility for benefits.
- If the person or entity that receives the described protected health information is not a health care provider or a health plan covered by federal privacy laws, the information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving person or entity and, upon redisclosure, may no longer be protected by federal privacy laws.

VI. Signature of Participant or Participant's Representative

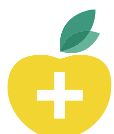
By my signature, I authorize the disclosure of the protected health information described above. I have read and understand this form. I am the participant listed or am authorized to act on behalf of the participant as the participant's personal representative.

Printed name of participant or
participant's personal representative ____

Signature of participant or
participant's personal representative ____ Date___________________

If the form is signed by a personal representative, complete the following information:

Relationship to the participant, including authority to act as personal representative ____________________________________



ProBenefits
The benefit of trust.

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