



AUTHORIZATION FORM FOR INFORMATION RELEASE

You may authorize your administrator in writing to share your health information with a third party such as an employer, lawyer, individual broker or unrelated party by completing and submitting this authorization form.

Please print neatly to ensure correct and prompt processing. We reserve the right to return any illegible or incomplete forms.

I, the undersigned, authorize **CareFlex Benefit Solutions** to release information from the records of:

Name: _____ Date of Birth: _____

Social Security #: _____

Address: _____

Home Phone: _____ Work Phone: _____

Information authorized for release (check all that apply):

- _____ Account Balance Information
- _____ Claims/EOB Information
- _____ Enrollment and Benefit Information
- _____ Other: _____

Information may be released to:

1. Name of Individual or Organization: _____
 Street Address: _____
 City, State, Zip: _____
 Telephone: _____

2. Name of Individual or Organization: _____
 Street Address: _____
 City, State, Zip: _____
 Telephone: _____

3. Name of Individual or Organization: _____
 Street Address: _____
 City, State, Zip: _____
 Telephone: _____

The information will be used or disclosed for the following purposes (describe the reason for each use and disclosure of the protected health information or indicate "at the request of the individual"):

Please read each of the following statements carefully before signing this document.

1. I understand that this authorization will expire one year from the date signed unless a shorter time frame is requested or specific event has occurred.

Date to expire (can not exceed one year from date signed): _____

After a specific event has occurred: _____
(e.g., denied claim or account renewal)

2. I understand that this authorization is voluntary and being made at my request.
3. I understand that the released information may no longer be protected by federal privacy laws and may be redisclosed by the individual or organization that receives the information.
4. I understand that I may refuse to sign this authorization. My benefit plan will not condition payment, enrollment, or eligibility of benefits on my signing this authorization.
5. I understand that I may revoke this authorization at any time by sending a written notification to the address listed below and this revocation will be effective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective (i) for information that has already been disclosed, relying on this authorization, or (ii) if the authorization was obtained as a condition for coverage in my plan, and, by law, the plan has a right to contest the coverage.
6. By signing this form I revoke any previous Authorization Form for Information Release signed by me at an earlier date.

Signature: _____ Date: _____

If the person signing this form is not the member, the parent, or guardian of a dependent under the age of 18, you must attach a full copy of the official document indicating your legal authority to sign on behalf of the member (i.e., Power of Attorney, Court Assigned Guardian, Personal Representative, etc.).

If you need help completing this form, please call 1-888-577-2762.

Please mail or fax this authorization to:

CareFlex Benefit Solutions
205 West Dares Beach Road
Prince Frederick, MD 20678
(410) 414-8432 Fax

Please keep a copy of the authorization.

Any mental health or substance abuse information, which has been disclosed from medical or other health care records, may be protected by federal and/or state law. If the records are so protected, Federal Regulation (42CFR Part 2) prohibits the recipient of the information from making any further disclosure of this information unless such disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.