Protected Health Information (PHI)

Authorization/Revocation for Use or Disclosure

Generally, except as permitted by law, Benefit Resource, LLC cannot disclose your Protected Health Information ("PHI") to someone other than you or allow another person to use your PHI, unless you authorize such disclosure. PHI is information that relates to your past, present, or future physical or mental health, health care, or payment for health care, and either identifies you or provides a reasonable basis for identifying you.

Employee Name

Employer

Street or PO Box

Member ID *(set by your employer. Typically an employee ID or SSN.)*

City State ZIP

Authorization or revocation: ☐ Authorization ☐ Revocation

☐ Please check this box if authorization is due to death or incapacitation of participant *(form must be signed by employer representative)*

Person or entity:	Relationship to participant:		
1.	☐ Spouse	☐ Child	☐ Other
2.	☐ Spouse	☐ Child	☐ Other
3.	☐ Spouse	☐ Child	☐ Other
4.	☐ Spouse	☐ Child	☐ Other
5.	☐ Spouse	☐ Child	☐ Other

By completing this section, you are authorizing Benefit Resource to disclose or revote access to your PHI associated with all your accounts to the person or entity identified above.

Please certify the following:

If PHI access is being authorized:

- I hereby authorize the use or disclosure of my PHI as described above.
- I understand that the recipient of my PHI pursuant to this authorization may re-disclose the information and may not be required to keep the information confidential.
- I understand that I am under no obligation to sign this form and that the Plan may not condition treatment, payment, enrollment or eligibility for health care benefits on my decision to sign this authorization.
- I understand that I may revoke this authorization at any time by submitting my revocation, in writing, to Benefit Resource. I am aware that my revocation will not be effective as to uses and/or disclosures of my PHI that the person(s) and or organization(s) listed above have already made in reference to this authorization
- This authorization remains in effect until written revocation is received by Benefit Resource.

If PHI access is being revoked:

- I hereby revoke my prior authorization allowing Benefit Resource to disclose Protected Health Information (PHI) associated with all my accounts to the above individuals.
- I understand this revocation of my PHI authorization will not affect any action taken by Benefit Resource prior to receiving this written notice.

Signature

Date *(MM/DD/YYYY)*