Authorization for Use or Disclosure of Protected Health Information

Generally, except as permitted by law, Benefit Resource, Inc. 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. By executing this form you are authorizing Benefit Resource to disclose your PHI associated with all your accounts to the person or entity identified below.

I hereby authorize the use or disclosure of my PHI as described below *(please print clearly)***:**

1. Person or entity to whom my PHI may be disclosed or who may use my PHI:
   ____
   ____
2. 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.
3. 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.
4. 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.
5. This authorization remains in effect until written revocation is received by Benefit Resource.

Participant's Name: ____

Member ID: ____

Home Address: ____

____

Name of Employer: ____

________________________________ ________________________

Signature of Participant ***Date***

Return completed form to:

Attn: Participant Services
Benefit Resource, Inc.
245 Kenneth Drive
Rochester NY 14623-4277
Fax: (585) 424-7273