

Simplified Benefits Administrators Personal Health Information (PHI) Release Form



AUTHORIZATION FOR THE USE AND DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

Authorization Effective Date:	Member Name:
Authorization Expiration Date:	Member ID Number:
Specific description of information that may be used or disclosed:	
The information will be used/disclosed for the following purpose(s):	
Persons/organizations authorized to use or disclose the information:	
Persons/organizations authorized to receive the information:	

1. The person/organization authorized to use/disclose the information (Simplified Benefits Administrators) will not receive compensation for doing so.
2. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Health information will not be disclosed by Simplified Benefits Administrators to another party without my signed authorization. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for or coverage of services, or ability to obtain treatment.
3. I understand that I may inspect or copy the information used or disclosed.
4. I understand that I may revoke this authorization at any time by notifying Simplified Benefits Administrators in writing, except to the extent that:
 - a. Action has been taken in reliance on this authorization; or
 - b. If this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.
5. I understand that I have a right to request and receive a Notice of Privacy Practices from Simplified Benefits Administrators
6. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

I hereby authorize the use or disclosure of my individually identifiable health information as described below.

Signature of patient or patient's representative

Date

Printed name of patient or patient's representative

Relationship to patient or representative's authority to act for the patient, if applicable

A copy of this signed form will be provided to the patient.

Please submit the form using one of the following options.

Email: customerservice@simplifiedbenefitsadministrators.org

Fax: 801.442.0041