AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PARTICIPANT NAME: _____

SOCIAL SECURITY NUMBER: _____

I authorize U.S. BENCOR/MidAmerica and its business associates to disclose **claims, payment, and other related health information about me** (other than psychotherapy notes) to the following persons (select 1-2 persons, if desired):

NAME 1: _____
RELATIONSHIP: _____
SOCIAL SECURITY NUMBER: _____
DATE OF BIRTH: _____
DATES FOR GIVEN AUTHORIZATION: _____
PLAN NAME: _____
TYPE OF ACCESS REQUESTED:

☐ **INFORMATION ONLY** (Authorized person may call to obtain account information, such as balance, plan information, statements)

☐ **FULL ACCESS** (Includes online access, submit claims, ability to make changes, such as beneficiary designations*, account census updates, manage investments*)

NAME 2: _____
RELATIONSHIP: _____
SOCIAL SECURITY NUMBER: _____
DATE OF BIRTH: _____
DATES FOR GIVEN AUTHORIZATION: _____
PLAN NAME: _____
TYPE OF ACCESS REQUESTED:

☐ **INFORMATION ONLY** (Authorized person may call to obtain account information, such as balance, plan information, statements)

☐ **FULL ACCESS** (Includes online access, submit claims, ability to make changes, such as beneficiary designations*, account census updates, manage investments*)

I understand that this authorization will expire when I lose my plan eligibility and am not reinstated. I understand that I have the right to revoke my authorization by advising the plan administrator in writing. This revocation will not be effective to the extent that the authorization has already been relied upon.

*If applicable to plan

I understand that my health information that is disclosed pursuant to this authorization may be disclosed by the persons I have identified above AND I understand that I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).

PLEASE NOTE: A wet signature is required for processing, as well as the driver's license or government-issued identification for the participant and the named individual(s) on the form.

PARTICIPANT SIGNATURE: _____ DATE: _____

-OR-

REVOCATION OF AUTHORIZATION:

☐ I do not want my Health Information released to anyone but myself.

PARTICIPANT SIGNATURE: _____ DATE: _____

Please keep a copy of this release form for your records and submit a completed form, along with any required documentation, to:

Mail:
U.S. BENCOR/MidAmerica
Dept: HRA Admin
PO Box 24927, Lakeland, FL 33802

Fax:
(863) 686-9727
Questions?
(855) 329-0095