Authorized Representative/ HIPAA Form

BenefitHelp SOLUTIONS

PLEASE PRINT CLEARLY

*** This information is mandatory.** Form processing may be delayed if fields with an asterisk are not filled out.

Instructions

1. Complete all sections of this form.
2. Securely email, mail, or fax completed form and supporting documentation to:
   Secure Email: BenefitHelpSolutionsCDHSupport@healthaccountservices.com
   Address: BenefitHelp Solutions, P.O. Box 2823, Fargo, ND 58108
   Fax: (855) 778-9837
3. If you have any questions about completing this form, please contact BenefitHelp Solutions Consumer Services at (855) 378-0197.

This form is used to document the designation of an Authorized Representative for a consumer. This form authorizes the release of medical information to the representative named below. This authorization does not provide your Authorized Representative with any authority, either implied or direct, over any direct care decisions or account management. If you wish to set up a Power of Attorney or Living Will, please discuss this with your attorney. We will not conduct benefit payments, enrollment, or eligibility for benefits on the execution of this form. To remove an Authorized Representative, complete Steps 1, 3 and 4 on this Form. The Date of Revocation cannot be retroactive. If a retroactive date is indicated, the revocation will be administered effective as of the date this Form is received by us.

Section 1 Account holder information

* First name	M.I.	* Last name	* Date of birth _____ / _____ / _____	* Social Security number
* Contact phone number			* Employer	

Section 2 Authorized Representative Information

* Authorized representative name			* Date of birth _____ / _____ / _____
* Social Security number			* Phone number
* Permanent address	* City	* State	* Zip code

Section 3 Revocation of Authorized Representative (Complete only if removing an Authorized Representative)

I hereby revoke the appointee previously named Authorized Representative and have notified them of this change.

* Authorized Representative Name	* Date of Revocation

Section 4 Authorized Use & Disclosure

I understand that due to HIPAA and other privacy regulations, BenefitHelp Solutions will not disclose my personal health information to other parties without my written authorization or as permitted or required by law. For this reason, I authorize you to discuss and disclose my personal health information to the person(s) named above for the purpose of assisting with, or facilitating, the coordination or payment of my health benefits. I also understand that if my Authorized Representative is not a healthcare provider or another entity subject to federal or applicable state privacy laws, my personal health information may no longer be protected by those privacy laws, and my Authorized Representative may further disclose my personal health information without my authorization. I acknowledge that my authorization is voluntary.

I understand I have the right to revoke or end this authorization at any time. I understand that if I do not wish the person named in Section 2 to remain my Authorized Representative, I must revoke this authorization in writing by completing Sections 1, 3 and 4 of this Form thus giving notice of my decision to BenefitHelp Solutions. I understand that my revocation of this authorization will not affect any action that has been taken, or any information that has already been released based upon this authorization before BenefitHelp Solutions actually received my request to revoke it. I acknowledge that this form may be electronically signed, and I agree that the electronic signature(s) appearing on this document are the same as handwritten signatures for the purpose of validity, enforceability, and admissibility.

* Consumer signature	* Date