

# Authorization to Release Protected Health Information to Family Members or Designated Individuals

I hereby authorize the use of disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information. Any uses or disclosures already made with my permission cannot be taken back. I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected under federal law. (Please complete a separate form for each individual covered under the plan who wants to share information.) Information obtained or disclosed with this authorization will be limited to the minimum information needed to achieve the purpose.

Member Name: \_\_\_\_\_ Member ID#: \_\_\_\_\_

Current or Former Employer Name: \_\_\_\_\_

## I authorize BenefitHelp Solutions to obtain and disclose my Protected Health Information to:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

### For the purpose of:

- Enrolling in a health plan
- Disenrolling from a health plan
- Eligibility for coverage
- Billing and Premium Payments
- Other: \_\_\_\_\_

### This authorization shall be in force and in effect until the following date OR event:

Date: \_\_\_\_\_ (not to exceed 24 months) / Event: \_\_\_\_\_

### I have reviewed and I understand this Authorization:

Member Signature: \_\_\_\_\_ Date: \_\_\_\_\_

– OR –

Member's Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Member: \_\_ Parent \_\_ Legal Guardian\* \_\_ Hold Power of Attorney\*

\*Please attach legal documentation of you are the legal guardian or Holder of Power of Attorney

***\*All fields must be completed for this Authorization to be valid\****  
**Member must be given a copy of the completed form**

**To revoke this Authorization, please send a written statement to:**  
BenefitHelp Solutions • Attn: Privacy Office  
P.O. Box 40548 • Portland, OR 97240-0548 or Fax: 1-888-393-2943  
Customer Service Phone #: 503-765-3581 or 1-800-556-3137  
www.benefithelpsolutions.com