AUTHORIZATION FORM

Use & Disclosure of Protected Health Information

This form will allow Benefit Analysis, Inc. to release Protected Health Information to the person(s) or entities specified on this form.

PERSON AUTHORIZING RELEASE

EMPLOYEE/PARTICIPANT NAME: ______________________________

EMPLOYER: ______________________________

DATE OF BIRTH: ______________________________

SOCIAL SECURITY # (Last Four Digits Only): XXX XX ________

ADDRESS: ______________________________

PERSONS/ENTITIES RECEIVING AUTHORIZATION

I authorize the persons or entities below to obtain and/or review my Protected Health Information:

☐ Benefit Analysis, Inc. (to review and/or assist with claim matters)

☐ Other: ______________________________

Relationship: ______________________________

☐ Other: ______________________________

Relationship: ______________________________

☐ Other: ______________________________

Relationship: ______________________________

Purpose for releasing information: ______________________________

This authorization expires: upon termination of employment (expiration may be altered by Employee/Participant)
(date or event)

SIGNATURE

I understand that information used or disclosed based on this authorization may be subject to re-disclosure by the recipient and will no longer be protected by federal privacy regulations. I understand that I may revoke this authorization by sending a written request to Benefit Analysis, Inc. PO Box 527, Nutley, NJ, 07110. The provision of treatment, payment, enrollment or eligibility for benefits does not depend on whether you sign this authorization.

______________________________ ______________________________
MEMBER/PARTICIPANT SIGNATURE DATE

A copy of this signed authorization form will be maintained by Benefit Analysis, Inc. and can be provided upon request. However, it is recommended that you keep a signed copy for your records.

To return your completed form, please fax it to 1-973-661-2888
or mail it to Benefit Analysis, Inc, PO Box 527, Nutley, NJ, 07110