

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

INDIVIDUAL DATA

Individual's Name: _____

Group Health Plan Name: _____

Group Number: _____

Address, City, State and Zip: _____

Telephone No.: _____

I authorize the use and disclosure of my protected health information as described below:

1. My protected health information is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, health plan, my employer, or a health care clearinghouse, and that relates to: (1) my past, present or future physical or mental health or condition; (2) the provision of health care to me; or (3) the past, present or future payment for the provision of health care to me.
2. The following individual is authorized to disclose to Allied Benefit Systems, Inc. ("Allied") all my protected health information, and also receive from Allied all my protected health information:

3. I understand that if my protected health information is to be received by an individual or organization that is not a health care provider, health care clearinghouse or health plan covered by federal privacy regulations, my protected health information described above may be re-disclosed and no longer protected by federal privacy regulations.
4. I understand that I may revoke this authorization at any time by mailing/faxing a written notification to Allied at the address below, in care of Donna Spurr, and this revocation will be effective for future uses and disclosures of protected health information.

However, I further understand that this revocation will not be effective: (1) for information that my Group Health Plan (GHP) already has used or disclosed, relying on this authorization or (2) if the authorization was obtained as a condition for coverage in my GHP and, by law, my GHP has a right to contest the coverage.

Individual Signature:

Date: _____

Individual Name
(Please Print): _____

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