MEMBER'S AUTHORIZATION REQUEST FORM

You may give your Health Plan and ACS Benefit Services, LLC (ACS) written authorization to disclose your Protected Health Information (PHI) to anyone that you designate and for any purpose. If you wish to authorize a person to receive your PHI, please complete the information below. **Completion of this form will not change the way ACS communicates with Members, including Subscribers. For example, ACS will still send explanation of benefits (EOB) statements to the Subscriber.**

Member's (your) Name_____ Subscriber's Name (if different)_____

Member's Date of Birth___/___/_____

Subscriber ID Number_____ Plan ID number (from ID card, if applicable) _____

At my request, I authorize my Health Plan and ACS to disclose my Protected Health Information to: (enter name of person who will receive your PHI).

_____

(Name) (Address) (Relationship to Member)

Please provide the following information to the person you have authorized so that we may verify the person's identity and authority to receive your PHI:

For Subscriber giving authorization: Subscriber ID Number, Subscriber Date of Birth, Subscriber Address, and Subscriber Name.

For Member (if different from Subscriber): Subscriber ID Number, Member's Name, Member's Date of Birth and Member's Address.

NOTE: This information must be the same as the information ACS has on file from the Employer's Health Plan.

I authorize my Health Plan and ACS to disclose the following PHI to the person listed above. Check all that apply:

___Enrollment Information
___Premium Payment Information
___All Claims Information
___Benefit Information
___Explanation of Benefits (EOB) Information
___Any Information Requested

___All services from a specific health care provider (List provider's name): _____

__ Other (Please list specific PHI): _____

I would like this Authorization to expire on (enter date):_____/_____/_____.
If no expiration date is provided, this authorization will not expire until revoked by me in writing.

I understand that I may revoke this Authorization at any time by giving the Group Health Plan written notice. However, if I revoke this Authorization, I also understand that the revocation will not affect any action the Group Health Plan or ACS took in reliance on this Authorization before the Group Health Plan or ACS received and processed my written notice of revocation.

I also understand that the authorized person can receive PHI for any time prior to and subsequent to the effective date of this Authorization, unless this Authorization specifically limits any date or dates.

I also understand that the Group Health Plan will not condition the provision of health plan benefits on this Authorization.

I also understand the potential for information disclosed pursuant to this Authorization to be further re-disclosed by the person I have authorized to receive my PHI, and that this information may no longer be protected by the Health Insurance Portability and Accountability Act ("HIPAA"), a federal health information privacy law.

_____ _____

Signature (Member Giving Authorization) Date

If signed by a personal representative of the Member giving authorization:

Print your full name _____

Describe your authority to act for the Member (e.g. power of attorney, court order, parent of minor child, etc.):

_____

You must attach the legal document naming you as the personal representative if you have not previously submitted it to us.

Note: ACS will consider the effective date of this Authorization to be the date ACS enters this Authorization into its system, typically five (5) days following receipt by the Privacy Office. If you would like this Authorization to become effective on a date later than the date ACS enters the Authorization into its system, please insert the date here:_____/____/_____.

RETURN THIS AUTHORIZATION TO THE PRIVACY OFFICIAL AT THE OFFICE OF THE EMPLOYER

Received By: _____
Date: _____(Privacy Official – Employer's Office)

Employer's Name: _____