Acclaris Reimbursement Center
Authorization for Release of Personal Health Information

This document authorizes Acclaris, Inc. to use and disclose Protected Health Information ("PHI") currently maintained by Acclaris, Inc. subject to the specifications listed below. Authorization may be revoked by the employee/dependent authorizing the release at any time. Unless otherwise revoked (see Section F. Right to Revoke below), this authorization expires one year from the date it is signed.

Section A. Employee Information

Employee Name: _____
Employee Social Security Number: _____
Employee Date of Birth: _____
Employer: _____

Section B. Employee/Dependent for Whom Information will be Released

This document authorizes the use and/or disclosure of confidential protected health information about the following employee or dependent (spouse, adult or minor dependent, or domestic partner).

Name: _____
Address: _____
City, State and Zip Code: _____
Social Security Number: _____
Date of Birth: _____
Daytime Phone Number: (_____)_____

Section C. Directions for Release

This authorization applies in accordance with my directions as checked below. I authorize the Acclaris Reimbursement Center to release and/or use protected health information pertaining to the employee/dependent listed in Section B. I understand that the information to be disclosed and/or used may include enrollment information, eligibility information, premium (payment) information, claims records and claims status.

CHECK ALL THAT APPLY IN SECTION C.1 and C.2:
C.1 I authorize the disclosure and/or use of the following information:
_____(a) any information related to reimbursement request(s) and payments
_____(b) my enrollment, eligibility and premium payment records
_____(c) Other (describe information in detail): _____
_____
C.2 I authorize the disclosure and/or use for the following reason(s):
_____(a) for review and questions of a claim
_____(b) for review and questions of payments
_____(c) for review and questions of my elections
_____(d) Other (describe information in detail): _____
_____

Section D. Person or Entity to Whom Disclosure Will be Made

Name: _____
Address: _____
City, State and Zip Code: _____
Phone Number: (_____)_____

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Section E. Authorization and Signature

I authorize the release of my confidential protected health information, as described in my directions in Section C and Section D. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is covered by Florida law which prohibits redisclosure or other laws that limit the use and/or disclosure of my confidential protected health information. Redisclosure by the recipient may occur without my knowledge or consent and the privacy of my personal health information may no longer be protected. My treatment, payment, enrollment and eligibility are not conditioned on signing this authorization but the information authorized may be necessary for claim review and appeal purposes.

I,_____, have read the contents of this Authorization, and I confirm that the contents are consistent with my directions. I understand that by signing this form, I am authorizing the use and/or disclosure of my confidential protected health information.

_____ _____

Signature Date

Section F. Right to Revoke

You may revoke this authorization at any time. (Please allow five business days from the date Acclaris receives the revocation for Acclaris to register the information.) To revoke this authorization, please sign and date below and return the entire completed form to Acclaris at the address below. If you have any questions, please contact the Acclaris Reimbursement Center at 1-866-203-9358.

I hereby revoke my authorization for the release of health information as listed on this form above. I understand that this revocation shall not apply to any action already taken by Acclaris in reliance on the above authorization.

_____ _____

Signature Date

Section G. Legal Representative

Please attach a copy of your power of attorney or a certified copy of your Court Order of your representative capacity. If you are signing on behalf of a minor child, your signature below constitutes your certification that you are the natural guardian of the minor child.

If a Legal Representative (Guardian, Conservator, or Authorized Representative) on behalf of the individual signs this authorization, complete the following:

Legal Representative's Name (PRINTED): _____

Legal Representative's Signature: _____

Date: _____ Daytime Phone Number: (_____)_____

If this authorization is being requested/signed by the Legal Representative, you must furnish a copy of the Power of Attorney or other relevant documents designating you as the representative of the individual.

Complete, sign and return this form to:
Acclaris Reimbursement Center
P.O. Box 25171, Lehigh Valley, PA 18002-5171
or fax to 1-813-830-7900