

FLEXIBLE BENEFIT ADMINISTRATORS, INC.

P.O. Box 8188
Virginia Beach, VA 23450
Phone: (800) 437-3539
Fax: (757) 431-1155

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

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Full Name: _____

Company Name: _____

Date of Birth: _____ Social Security #: _____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make the disclosure:

Name: _____

Address: _____

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

____ Enrollment

____ Payment

____ Claims adjudication

____ Case or medical management records including:

____ Problem(s) [list] from (date) _____ to (date) _____

____ Medications(s) [list] from (date) _____ to (date) _____

____ Most recent history and physical

____ Most recent discharge summary

____ Laboratory results from (date) _____ to (date) _____

____ X-ray and imaging reports from (date) _____ to (date) _____

____ Consultation reports from (doctors' names) _____

____ Entire record from (date) _____ to (date) _____

Other _____

4. This information may be disclosed to and used by the following individual or organization:

Name: _____

Address: _____

5. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Flexible Benefit Administrators, Inc. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the date, event, or condition listed below:

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6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed. I understand that I any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Privacy Committee at Flexible Benefit Administrators, Inc.

Signature of employee, plan participant, or legal representative:

_____ Date _____

If signed by legal representative, list the authority to act for employee/plan participant:

Signature of witness:

_____ Date _____