Authorization for Release of Information

beneliance

Information about the Use or Disclosure

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary and that I may refuse to sign this authorization and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information.

Participant Last Name _____ First Name _____ Middle Initial _____
(Please Print)

Employer Name _____

Persons authorized to receive the information on behalf of the participant:

1. Last Name _____ First Name _____ Middle Initial _____
   Relationship _____
2. Last Name _____ First Name _____ Middle Initial _____
   Relationship _____
3. Last Name _____ First Name _____ Middle Initial _____
   Relationship _____
4. Last Name _____ First Name _____ Middle Initial _____
   Relationship _____
5. Last Name _____ First Name _____ Middle Initial _____
   Relationship _____

Description of information authorized to be used or disclosed: _____

_____

_____

Purpose of the disclosure: _____

_____

Important Information About Your Rights

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time by notifying the providing organization in writing, but the revocation will not have any effect on any actions that the entity took before it received the revocation.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive my health care benefits (enrollment, or payment)
- The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving entity.

Signature _____ **Date** _____/_____/_____
mm/dd/yy

Beneliance | PO Box 55068 | Little Rock, AR 72215
Phone 501-687-6954 | Toll-Free Fax: 855-445-1696 | benefits@beneliance.com | beneliance.com