



MEMBER'S AUTHORIZATION REQUEST FORM

You may give your Health Plan and ACS Benefits Services, Inc. (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 _____ Member's Date of Birth ____/____/____
Month Day Year

Subscriber's Name (if different) _____ Subscriber ID Number _____
(Usually the Employee) (This is the number on ID card)

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 boxes that apply OR Check "Other" and be specific

- | | |
|--|---|
| <input type="checkbox"/> Any Information Requested
<input type="checkbox"/> All Claims Information
<input type="checkbox"/> Explanation of Benefits (EOB) Information
<input type="checkbox"/> Enrollment Information
<input type="checkbox"/> Other (Please list specific PHI): _____ | <input type="checkbox"/> Benefit Information
<input type="checkbox"/> Premium Payment Information
<input type="checkbox"/> All Services from a specific health care provider
(List provider's name): _____ |
|--|---|

(Use only if no box is checked above)

I would like this Authorization to expire on (enter date): ____/____/____.
Month Day Year

If no expiration date is provided, this authorization will expire when 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.
- 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.
- that the Group Health Plan will not condition the provision of health plan benefits on this Authorization.
- 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

Date

If signed by an individual other than the Member:

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.

**NOTE: The effective date of this Authorization will be no earlier than the date ACS enters this Authorization into its system, typically within five (5) business days following receipt by the ACS 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: _____/_____/_____.
Month Day Year**

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

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

Employer’s Name: _____