**Instructions: You may complete the form by typing in the information and using the tab key to advance to the next blank. All fields must be completed. Then press the "Print Form" button, sign and fax (or mail). If you prefer, you may print the blank form and print the information by hand. Be sure to sign and date before submitting the completed form.**

BENEFIT SOLUTIONS, INC.

# AUTHORIZATION REQUEST FORM

*You may give Benefit Solutions, Inc. (BSI) 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 or entity to receive your PHI, please complete the information below.*

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Insured's Full Name

Date of Birth

Phone Number

Group Number

Social Security Number

Name

Address

Relationship to Insured

*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: (i) your social security number (ii) your date of birth, and (iii) address.*

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I would like this authorization to expire on (enter date): (MM/DD/YYYY)

(If no expiration date is provided, this authorization will expire twelve (12) months from the date of receipt.)

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I understand that I may revoke this authorization at any time by giving Benefit Solutions, Inc., written notice mailed to the address below. However, if I revoke this authorization, I also understand that the revocation will not affect any action BSI took in reliance on this authorization before BSI received my written notice of revocation.

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I also understand that if the persons or entities I authorize to receive my PHI are not health plans, covered health care providers or health care clearinghouses subject to the Health Insurance Portability and Accountability Act ("HIPAA") or other federal information privacy laws, that they may further disclosure the PHI and it may no longer by protected by HIPAA or federal health information privacy laws.

Signature: ______________________________ Date: ____________

RETURN THIS AUTHORIZATION TO:

BENEFIT SOLUTIONS, INC.
PO BOX 385
TAYLORSVILLE, NC 28681