

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION



P.O. Box 21367 Billings, MT 59104-1367
Phone: 800.777.3575 • Fax: 406.652.5380 • Website: www.ebms.com

The Individual:
Address:

Group Name or Number:

Please note that completing this form will not allow online access to information through miBenefits. To grant online access please follow the instructions on the reverse side of this authorization.

This Authorization is provided in accordance with the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Standards") issued under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA").

I, _____ (DOB ___/___/___), am a participant in the above referenced Plan and hereby authorize the use or disclosure of my protected health information as described in this Authorization.

1. Specific person(s)/organization authorized to provide the information.

EBMS, INC.

2. Specific person(s)/organization authorized to receive and use the information.

3. Specific description of the information to be used and/or disclosed.

I, _____, hereby understand the following:

4. Right to revoke: I understand that I have the right to revoke this Authorization at any time by notifying the Third Party Administrator, in writing, at the appropriate address set forth above. I understand that the revocation is only effective after it is received and logged by the Third Party Administrator. I understand that I cannot revoke this authorization to the extent that action has been taken in reliance of this authorization (for example, any use or disclosure made prior to the revocation under this Authorization will not be affected by the revocation).
5. I understand that after the information that is the subject of this Authorization is used or disclosed, the Privacy Standards may not protect it and the recipient may redisclose it.
6. I understand that this Authorization is not required for the Plan to use or disclose this information for purposes of treatment, payment or health care operations, or if the use or disclosure is otherwise permitted by the Privacy Standards, and that any revocation of this Authorization will have no effect on such uses or disclosures.
7. I understand that I am entitled to receive a copy of this Authorization.
8. I understand that this Authorization will automatically renew at the beginning of each calendar year unless otherwise revoked pursuant to the provisions outlined in paragraph 4 above. I further understand that this Authorization will permanently expire when the Individual's coverage under the Plan terminates, or when the Individual has no further claims for which payment is requested under the Plan, whichever is later.

Date

Individual

If a personal representative executes this form, that representative warrants that he or she has authority to sign this form on the Individual's behalf on the basis of _____
Documentation Required (POA/Guardianship/etc.)

Date

Personal Representative

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HIPAA Authorization Instructions

In executing the Authorization, you will need to do the following:

1. Insert your name and address where indicated;
2. In Paragraph #2 you can insert the individual(s) you would like to have access to your information;
3. In Paragraph #3 you can insert the type of information to be disclosed. This can be as broad as you wish. It can say "any and all protected health information, including access to information on miBenefits" or it can be more specific. NOTE: If you want to allow another person access to your minor child(ren)'s information, please state the name(s) of the minor child(ren) in this Paragraph; and
4. Sign and date the Authorization.

Once you have executed the document, you can return the signed document to EBMS at P.O. Box 21367, Billings, MT 59104-1367, or you can fax it to (406) 652-5380.

Please note that completing the paper authorization form will not allow online access to information through miBenefits. To grant online access please follow the instructions below.

HIPAA Authorization Instructions through miBenefits

You may also grant access to the miBenefits website at www.ebms.com. You can electronically enter your authorization after logging on to the website.

1. Log into your miBenefits account. If you don't have an account, create an account by registering.
2. Select Update Account; located in the navigation strip at the top of the page.
3. Select Submit/ Update HIPAA Authorization.
4. Complete the required fields, and submit the form.

Authorizations are required for spouses and dependent children 18 years or older. Minor children are not required to execute Authorizations.