How to Complete this Form

The "Member Authorization to Disclose Health Information" form must be completed in its entirety and signed by the member in order to be a valid authorization. Incorrect or incomplete forms will not be accepted. The steps outlined below are provided to assist you with the proper completion of this form. Please contact our Member Services Department at 1-800-342-5209 if you should have any questions.

Please neatly print or type the member's name, date of birth, address, phone number, and identification number in the first section of the form where indicated. The identification number is found on the member's I.D. card or you may use member's Social Security number.

1) Skip item #1 since we have filled this in for you.

2) In item #2, list the name of the person or name of the organization that the member is authorizing to receive the member's information. For example, if the member is authorizing the disclosure of information to the benefits administrator, then write "Jane Doe, benefits administrator". You must also list the address and phone number for such person or organization.

3) For item #3, specify the information that the member is allowing to be used or disclosed. The information must be identified in a specific and meaningful fashion. For example, if the member is authorizing the disclosure of specific claims information, then write "Claim from Dr. Doe for date of service of April 1, 2003."

4) In item #4, state the purpose for which the information authorized in item #3 may be used or disclosed. For example, if the information specified in item # 3 states "Claim from Dr. Doe for date of service of April 1, 2003" then the purpose listed in item #4 might be "To assist with the resolution of the claim."

5) Skip item #5 since we have filled this in for you.

6) For item #6, provide a date or event when the authorization expires. For example, this may be a calendar date such as "December 31, 2003" or an event such as "when coverage terminates."

7) In item #7, the member or the member's legal representative must sign and date the form. If the member's legal representative is signing on behalf of the member, then the legal representative must also print his/her name and state his/her relationship to the member. For example, if the parent is signing on behalf of a member who is a minor child, then the parent must also print his/her name and write "mother" or "father" as the relationship to the minor child.

The person completing the form must give the member a copy of the completed and signed form prior to sending it CompBenefits.

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The dental and vision benefits company of choice!

MEMBER AUTHORIZATION
TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy laws.

Member Name:_____ **Date of Birth:**_____

Address:_____ **Phone Number:**_____

I.D. Number:_____

1. **Person(s)/organization(s) authorized to use or disclose the information:**

   Person(s)/organization(s): CompBenefits

   Address: 100 Mansell Court E., Suite 400, Roswell, GA 30076

2. **Person(s)/organization(s) authorized to receive the information:**

   Person(s)/organization(s): _____

   Address: _____
   Phone Number: _____

3. **Specific description of the information that may be used/disclosed:**

   _____
   _____
   _____

4. **This information will be used/disclosed for the following purpose(s):**

   _____
   _____
   _____

5. **I understand that this authorization is voluntary and that I have the right to revoke this authorization. I must do so in writing and present my written revocation to:**

Person(s)/organization(s): CompBenefits
Attention: Privacy Officer

Address: 100 Mansell Court E., Suite 400, Roswell, GA 30076

6. **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 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 following:
Date:_____ **OR**
Event:_____

7. **I understand that I will be given a copy of this authorization form, after signing.**

Signature of Member or Legal Representative:_____

Date:_____

If signed by Legal Representative:_____
Print Name
Relationship to Member:_____

IMPORTANT NOTE:

In order to be valid, this form must be completed in its entirety. If you have any questions about this form or how to complete this form, please contact –

CompBenefits
Attn: Privacy Officer
100 Mansell Court East, Suite 400
Roswell, GA 30076
(770) 998-8936
PrivacyOfficer@CompBenefits.com

If you wish to revoke your authorization, please submit your request in writing to the Privacy Officer at the above address.