Lifetime
BENEFIT SOLUTIONS

AUTHORIZATION TO SHARE PROTECTED HEALTH INFORMATION

To comply with Federal HIPAA regulations, health plans must obtain a member's permission to share that member's protected health information with any other person. There are limited exceptions to this rule. Until a child reaches age 18, parents may access most of their child's health information without first obtaining the child's permission. However, regardless of the child's age, parents do not have access to diagnosis or treatment information, including payment information, for venereal diseases, abortion, and drug and alcohol abuse, unless the child specifically authorizes the release of such information.

As a member, you can use this form to authorize us to share your protected health information. Each person you identify will have the same access to your information. If you would like each person to access *different* information or to have access to your information for a *different* period of time, you'll need to complete separate forms for each individual or time period.

This authorization will include the disclosure of information relating to genetic testing, alcohol and drug abuse, mental health (excluding psychotherapy notes), abortion, and venereal disease information only if you place your initials on the corresponding line in Step 2. Additionally, if you would like to authorize us to release information regarding HIV/AIDS, a different form must be completed. To obtain a copy of this form please contact our office at the telephone number listed on your identification card, or access the form at the following website: http://www.health.state.ny.us/diseases/aids/forms/informedconsent.htm.

Your authorization is completely voluntary. Your enrollment in a health plan, eligibility for benefits, or payment of claims will not be conditioned on giving this authorization. If you need additional forms, you may copy this form, visit our Website at: http://www.ebsrmsco.com/Files/Forms/HIPAAAuthFSAHRA.pdf, or login to your account at: https://ebrparticipant.lh1ondemand.com/main.aspx or contact our office at the telephone number at 1-800-327-7130.

As permitted by law, we will continue to communicate to providers of care involved in your treatment: (1) our payment activities in connection with your claims, (2) your health plan enrollment information and (3) your eligibility for benefits.

- ☐ **Please check here if you would like to authorize access to psychotherapy notes. If this box is checked, then this authorization cannot be used for another reason. If checked, steps two and three on the disclosure form can be skipped.**

Please be sure to complete all of the following steps.

Step 1: Member to whom this authorization applies. *Please use one form per member.*

Name: _____

Address: _____

Members' last four digits of social security number _____

Birth Date: _____/_____/_____

Step 2: Reasons to share your information: *So Lifetime Benefit Solutions can:*

- ❑ Respond to all requests for confidential information about me made by the individual(s) or organization(s) I list below. I choose to include information regarding the following conditions in this authorization (please initial next to all that apply):

  _____ Genetic testing
  _____ Alcohol or substance abuse
  _____ Mental health
  _____ Abortion
  _____ Venereal diseases

  (Please note: You must complete a separate form to authorize release of information related to HIV/AIDS. The New York State-approved consent form can be found at: http://www.health.state.ny.us/diseases/aids/forms/informedconsent.htm

- ❑ Respond to requests for only the following specific information (such as claims submitted by a specific provider or information related to one of the protected diagnoses listed above):
  *Please specify*_____

- ❑ Respond to inquiries related to a specific date of service:
  *Please specify*_____

Step 3: Specific information you'd like us to share: *Please list the specific protected health information you wish us to disclose. Check all that apply:*

- ❑ My claim information (e.g. status, type of service, diagnosis, provider, dates of service payment date, payment method etc.)
- ❑ My membership information (e.g. coverage information, enrollment dates, eligibility, address, dates of birth, etc.)
- ❑ My benefit information (e.g. benefits available, benefits used, plan limits, etc.)
- ❑ My medical records (e.g. physician or hospital records, case management, etc.)
- ❑ Other information (please specify): _____
- ❑ Please exclude the following information: _____

Step 4: Indicate with whom you'd like us to share your information: *Please list the person(s) and/or organization(s) with which you want us to share the information you described above. Please remember if you'd like us to share information with more than one person, the information to be disclosed and the expiration date must be the same for each person.*

Name/Organization	**Address**
_____	_____
_____	_____
_____	_____

Step 5: **Indicate when you would like us to share your information:** *Please share my protected health information during the time period(s) below:*

- ❑ Until I send Lifetime Benefit Solutions a form canceling my authorization.
- ❑ From _____/_____/_____ through _____/_____/_____

Step 6: **Member signature:** *To give Lifetime Benefit Solutions authorization to share the protected health information noted above, please print your name on the line below and then provide your signature and today's date.*

I, _____, have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I confirm my authorization for the use, request and release of my confidential member protected health information as described in this form. I understand that I may cancel this authorization at any time by completing an authorization cancellation form and sending it to the address below. I also understand that the revocation of this authorization will not take effect until EBS-RMSCO receives my authorization cancellation form and will not affect any actions Lifetime Benefit Solutions took in reliance on this authorization before they received the authorization cancellation form.

I understand that the information disclosed as a result of this authorization may be subject to re-disclosure by the recipient, in which case it may no longer be protected under the federal privacy laws.

Signature: _____ **Date:**_____
(Member or Personal Representative)

If this request is by a personal representative on behalf of a member, please provide the following information:

Personal Representative's Name: *(please print)*_____

Description of Personal Representative's Authority (a power of attorney, legal guardian or state executor):

_____

Please note: Personal representatives must provide legal proof of representation, such as power of attorney documentation.

Please complete and return this form to:

Lifetime Benefit Solutions, Inc.
FSA Dept.
P.O. Box 6509
Syracuse, NY 13217

FAX: 877-256-7228

PLEASE RETAIN A COPY OF THIS FORM FOR YOUR RECORDS