Benefit Allocation Systems, Inc.
COBRA Control Services, LLC
AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI) and PERSONALLY IDENTIFIABLE INFORMATION

I hereby authorize Benefit Allocation Systems, Inc. and any of its subsidiaries and affiliates and their respective agents and subcontractors (hereafter collectively referred to as "BAS") to disclose the confidential information, including Protected Health Information (PHI) and/or Personally Identifiable Information (PII), identified below to the persons/organizations identified below for the purposes set forth on this form. I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that Protected Health Information (PHI) may include any information about me, including demographic information, that is created or received by a health care provider, health plan or health care clearinghouse. My PHI may relate to my past, present or future physical or mental health or condition, the provision of health care to me, or any past, present or future payment for my health care. PHI may identify me or there may be a reasonable basis to believe that the information can be used to identify me.

I understand that this Authorization is voluntary.

INDIVIDUAL AUTHORIZING DISCLOSURE

Name: _____ Telephone Number: _____

Date of Birth: _____ BAS/My Enroll Employee ID: _____

Employer Name: _____

DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED *[Please be specific - examples: claims information, eligibility, and payment]*:

_____

_____

_____

IMPORTANT NOTE: Unless this authorization is expressly limited, this authorization permits the use and disclosure of all of the personal information identified, including information about any diagnosis or treatment for any mental health, substance abuse, sexually transmitted disease (such as HIV), cancer and/or genetic condition for the purposes described.

WHO IS AUTHORIZED TO RECEIVE THE INFORMATION:

FIRST NAME	LAST NAME	RELATIONSHIP TO EMPLOYEE

CONTINUED….

REASON THE INFORMATION WILL BE USED OR DISCLOSED *[If the member initiates the authorization, the statement,* "at the request of the individual" *is sufficient]*:

_____

_____

_____

EXPIRATION DATE OR EVENT FOR AUTHORIZATION (*Specify when the authorization will expire)*

DATE _____

NOTICE OF RIGHTS:

You may revoke this authorization at any time. To revoke this authorization, send a written statement to the BAS Privacy Official:

BAS
Attn: Privacy Official
P.O. Box 62407
King of Prussia, PA 19406

Email: compliance@basusa.com

The statement must identify this authorization by referring to the date it was signed (below). The statement must include the date on which this authorization is no longer in force.

If you revoke this authorization, we may still use and disclose the information for the purposes listed above if we have already taken action in reliance on this authorization. Also, if this authorization is to permit BAS to disclose information to an insurance company in order for you to obtain insurance coverage, the insurance company may still have the legal right to use the information to contest a claim or to contest your coverage.

You may refuse to sign this authorization. You do not need to sign this authorization to receive services from BAS. You do not have to sign this authorization to receive payment, to enroll in your employer's health plan, or to be eligible for benefits.

A person or organization that receives your information because of this authorization may have the legal right to disclose the information to other people or organizations without your knowledge or consent.

Signature: _____ **Date**: _____

If this authorization is signed by someone who is not the member listed at the top of this form, provide the name of the authorized representative and a description of the signer's authority to act for the member.

Name
Address
City, State Zip

Relationship to Employee

_____

Authorized Representative's Telephone

_____

You may request a fully executed copy of this form.