ebms

The Benefit of Balance

HIPAA AUTHORIZATION INSTRUCTIONS

As a result of the Health Insurance Portability and Accountability Act of 1996, as amended (“HIPAA”), EBMS is no longer allowed to disclose your protected health information to third parties. If you wish to allow certain individuals to have access to your protected health information please execute the enclosed Authorization and return it to EBMS.

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.

You may also have access to the miBenefits website at www.ebms.com. You can electronically enter your authorization after logging on to the website in lieu of completing and returning the enclosed paper form.

If you have any questions or concerns, please do not hesitate to contact EBMS at (800) 777-3575.

Thank you.

Sincerely,

EBMS

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

P.O. Box 21367
Billings, MT 59104-1367

P 406.245.3575
T 800.777.3575
F 406.652.5380

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Terms used in this Authorization:

The Individual:	________________________________
Address:	________________________________
	________________________________
The Third Party Administrator:	Employee Benefit Management Services, Inc. (EBMS)
Address:	P.O. Box 21367 Billings, MT 59104-1367
The Plan:	________________________________

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, ____________________________, 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.

   Employee Benefit Management Services, Inc. (EBMS)

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