



PRIVACY AUTHORIZATION FORM

Administered by Benefit Management, Inc.

The purpose of this form is to authorize release of Personal Health Information and Personal Financial Information by OHRP, as the plan administrator, to the person(s) named on this form. This designation is voluntary and in no way affects benefits, claims processing and payment, or eligibility status.

Member Information

Member Name	Birth Date	Policy #
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Type of Information

OHRP may discuss or release Personal Health Information (PHI) and Personal Financial Information (PFI) to the person(s) named on this form. The following information may be released: eligibility, billing, payment status, benefits, claims, medical information used to make payment decisions, providers, appeals, and complaints about my health insurance coverage through OHRP, the health plan administrator.

Authorized Use and/or Disclosure

I authorize OHRP to release PHI and PFI to the person(s) named for the purpose of assisting with, or facilitating, the coordination or payment of my health plan benefits. I also understand that if my designated representative is not a health care provider, or other person subject to federal privacy laws, my PHI and PFI may no longer be protected by those privacy laws and may be subject to redisclosure by my designated representative. OHRP is not responsible should my designated representative further disclose my protected PHI and PFI information. I further understand that I have the right to limit the information that you release under this authorization. Limitations for disclosure are identified below. By leaving this section blank, I am creating no limitation on disclosure of PHI or PFI.

Disclosure Limitations: _____

Expiration and Revocation

The authorization to release information to the person(s) named on this form will automatically expire 365 days following the termination of my health plan enrollment. I understand that I may revoke this authorization at any time by giving written notice to the Plan administrator. Revocation will not affect any action that OHRP has taken, or any information that has already been released based upon prior authorizations.

Designation of Representative(s)

Name of Authorized Person	Relationship to Member	Last four digits of SS#
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Signature and Authorization

I, the undersigned, do hereby swear that I am the above-mentioned member or an authorized legal representative of the above-mentioned member. I have read and understand the content of this Privacy Authorization Form. My signed authorization is voluntary and I acknowledge that the information released may include protected and individually identifiable information about me.

Signature of Member/Legal Representative **Date**

Printed Name of Legal Representative **Description of Legal Representative's Relationship to Member**