Custom Design Benefits

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Last Name: _____ First: _____ Middle: _____ Maiden: _____

Address: _____ City: _____ State: ____ Zip: _____

Telephone: _____ Last 4 of SS#: _____ DOB: _____

Name of Employer: _____

The purpose of this request is for: ☐ At the request of the individual
☐ Other: _____

I authorize Custom Design Benefits to use and/or disclose the above named individual's health information as described below:

The type of information to be used or disclosed is as follows: _____
_____
_____
_____

I understand that the information in my record may include information relating to treatment, diagnosis, or testing of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological conditions, Acquired Immune Deficiency Syndrome (AIDS), and/or tests for antibodies to Human Immunodeficiency Virus (HIV).

The information identified above may be used by and/or disclosed to the following individual or organization:

Name: _____
Address: _____
Phone: _____ Fax: _____

I understand that I have a right to revoke this authorization at any time. I understand that if I want to revoke this authorization that I must do so in writing and present my written revocation to: Custom Design Benefits, Attn: Privacy Officer, 5589 Cheviot Road, Cincinnati, Ohio 45247. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for my benefits, unless the treatment is for research purposes or unless the provision of treatment is related solely to the disclosure of my PHI to a third party. I understand that this authorization shall remain in effect until termination of enrollment in this health plan unless I specify an earlier or later expiration date in this space: _____.
I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
I understand authorizing the use or disclosure of the information identified above is voluntary.

_____ _____
Participant/Legal Representative Signature* **Date**

If signed by legal representative, relationship to participant: _____
**Legal representative must provide guardianship, executor of estate, power of attorney papers with this form.*

Please return completed form via email to ROI@customdesignbenefits.com or mail to Custom Design Benefits, ATTN: Quality Assurance, 5589 Cheviot Road, Cincinnati OH 45247.