

Authorization For Release of Personal Health Information (PHI) to Non-Covered Health Plan Individuals

The purpose of this Authorization Form is to allow non-covered Health Plan Individuals (ie your non-covered spouse, dependent children or others who may be making payments on or inquiries on your behalf) with access to your personal health information (PHI). Under the new privacy regulations that were effective April 14, 2003, we cannot release PHI to anyone other than the plan participants, the former employer, health care providers, and insurance carrier(s) regarding your COBRA Account unless you authorize us to do so in writing.

The information that may be released to the individual listed below would be as follows:

- **Your Name, Social Security Number, Date of Birth, and Address**
- **The health plan(s) that you are covered under and their cost**
- **The dependents who are covered, their Social Security Number, Date of Birth and Address**
- **Payment history on your Account, including what your coverage is paid through, check numbers, amount paid and dates of deposit**

This form shall be effective until the next plan year or until your COBRA coverage ends, whichever event happens first. Each plan year you will be sent a new Authorization Form to be completed (usually during open enrollment, if applicable).

I hereby authorize the use or disclosure of my individually identifiable health information as described above to the following individual:

Name of Employer or Former Employer: _____

Authorized Individual's Name: _____

Relationship to Plan Participant(s): _____

Address: _____

Phone Number: _____ Email Address: _____

I (we) understand by signing this form that this authorization is voluntary, I (we) may revoke this authorization at any time by notifying BCL Systems, Inc. in writing and that I (we) must renew this authorization at the beginning of each plan year until my coverage ends under COBRA.

Employee Signature: _____

Spouse Signature* (if applicable): _____

Dependent**(if applicable): _____

Date _____

**Spouse must sign this form if he/she is a covered plan participant and agrees to have PHI released to the named individual.*

***Dependents over the age of 18 must sign this form if he/she is a covered plan participant and agrees to have PHI released to the named individual.*

Please return this signed form to BCL Systems, Inc. PO Box 307, Fox River Grove, IL 60021 or Fax it to (847) 516-2952.

CSR Use Only:

Group: _____ Date Received _____