



Complete and sign this form, return by fax to (601) 856-8088.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION, REIMBURSEMENT AUTHORIZATION AND/OR CLAIMING AUTHORIZATION

CAFETERIA PLAN HOLDER NAME: _____

EMPLOYER: _____

ADDRESS: _____

MEMBER SS# _____ TELEPHONE NUMBER: _____

DESCRIBE THE PROTECTED HEALTH INFORMATION "PHI" YOU ARE AUTHORIZING BE USED AND/OR DISCLOSED:

- A. PICK-UP REIMBURSEMENT AUTHORIZATION.** I AUTHORIZE SABC TO RELEASE MY CLAIMED REIMBURSEMENT CHECK TO THE PERSON(S) LISTED BELOW.
- B. OBTAIN MY REIMBURSEMENT INFORMATION, AND/OR ACCOUNT BALANCE(S).** I AUTHORIZE SABC TO RELEASE AND/OR DISCLOSE MY PHI TO THE PERSON(S) LISTED BELOW
- C. SIGN MY REIMBURSEMENT CLAIM FORM(S) ON MY BEHALF,** I AUTHORIZE THIS PERSON(S) LISTED BELOW AND REQUEST THAT SABC ACCEPT THEIR SIGNATURE ON MY BEHALF AND I ACKNOWLEDGE THAT I AM BOUND BY THE SAME STATEMENT OF TRUTH AS THE PERSON(S) I AM AUTHORIZING TO SIGN FOR ME, AND FOR THE EXPENSES THAT ARE BEING SUBMITTED ARE TRUE AND ELIGIBLE EXPENSES.
- D. OTHER** _____

NAME AND SPECIFICALLY DESCRIBE THE PERSON OR PERSONS WHO YOU ARE AUTHORIZING TO MAKE USE OF AND/OR TO DISCLOSE PHI.
PLACE THE LETTER(S) A, B, C, AND/OR D (LISTED ABOVE), NEXT TO LEVEL, THAT DESCRIBES THE LEVEL OF ACCESS YOU ARE AUTHORIZING EACH PERSON LISTED BELOW.

PERSONS AUTHORIZED TO USE OR DISCLOSE PHI ON MY BEHALF:

AUTHORIZED PERSON: _____ RELATION: _____ LEVEL: _____

AUTHORIZED PERSON: _____ RELATION: _____ LEVEL: _____

AUTHORIZED PERSON: _____ RELATION: _____ LEVEL: _____

AUTHORIZED PERSON: _____ RELATION: _____ LEVEL: _____

AUTHORIZED PERSON: _____ RELATION: _____ LEVEL: _____

THIS AUTHORIZATION IS VOLUNTARY AT THE REQUEST OF THE CAFETERIA PLAN HOLDER NAMED ABOVE.

EFFECT OF GRANTING THIS AUTHORIZATION: DISCLOSURE OF THE PHI YOU HAVE GRANTED WILL BE DISCLOSED TO AND/OR RECEIVED BY THE PERSON(S) LISTED ABOVE. THIS PERSON(S) MAY OR MAY NOT BE HEALTH PLANS, COVERED HEALTH CARE PROVIDERS OR HEALTH CARE CLEARING HOUSES SUBJECT TO FEDERAL HEALTH INFORMATION PRIVACY LAWS. THEY MAY FURTHER DISCLOSE THE PHI, AND IT MAY NO LONGER BE PROTECTED BY FEDERAL HEALTH INFORMATION PRIVACY LAWS.

EXPIRATION OF THIS AUTHORIZATION: THIS AUTHORIZATION WILL EXPIRE AFTER I AM NO LONGER ENROLLED IN THE CAFETERIA PLAN, UNDER MY CURRENT EMPLOYER'S PLAN, OR I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY GIVING WRITTEN NOTICE TO SABC. FUTURE REVOCATIONS OF THIS AUTHORIZATION WILL NOT AFFECT ANY ACTION OF DISCLOSURE OR RECIPIENT OF PHI YOU REQUESTED PRIOR TO THE DISCLOSURE OR RECIPIENT RECEIVING (IN HAND) YOUR WRITTEN NOTICE OF REVOCATION. A REVOCATION MAY BE DONE BY COMPLETING A REVOKE FORM. *YOUR REQUEST TO REVOKE WILL TAKE PLACE ON THE DATE WE RECEIVE YOUR REVOKE REQUEST.*

CAFETERIA PLAN HOLDERS SIGNATURE:

I, _____ (PRINT NAME), HAVE HAD FULL OPPORTUNITY TO READ AND CONSIDER THE CONTENTS OF THIS AUTHORIZATION, AND I UNDERSTAND THAT, BY SIGNING THIS FORM, I AM CONFIRMING MY AUTHORIZATION OF THE USE AND/OR DISCLOSURE OF MY PHI, AS DESCRIBED IN THIS FORM.

SIGNATURE: _____ DATE: _____