AUTHORIZATION TO RELEASE INFORMATION

I authorize the release to the human resources professional(s) responsible for the administration of the company's group health plan of _________________________ [**insert company name**] and Clark & Lavey Benefits Solutions, Inc. portions of my medical record that relates to any claim for benefits that I may have under such plan which such payment of benefits have either been delayed or denied by the health plan, including, but not limited to: diagnosis, duration of the condition, clinical course, prognosis, treatment and other information that may help with the resolution of any claim.

I authorize the health plan, and any physician or other care provider to disclose this information to the human resources professional responsible for the administration of the company's group health plan of _________________________ [**insert company name**] and Clark & Lavey Benefits Solutions, Inc., for the following purposes only: to assist me with resolution of any such claim and to conduct any plan operations related thereto.

I understand that, if my information is disclosed to someone who is not required to comply with state or federal privacy laws, then such information may be redisclosed and will no longer be protected by these regulations.

This authorization shall continue until such time as I am no longer a participant in _______________________ [**insert company name**] health plan. I understand that I have the right to revoke this authorization at any time. I am aware that my revocation is not effective to the extent that anyone, including the insurer or my physician and/or the company, has acted in reliance upon this authorization. I understand that my revocation must be submitted in writing to:

HIPAA Compliance Officer
______________________________ (Company Name & Address)
____
____

I understand that I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment nor affect my eligibility for benefits.

____________________________________ ______________________________
Signature Date

____
Print Name

A COPY OF THE SIGNED AUTHORIZATION SHOULD BE PROVIDED TO THE PARTICIPANT.