



AUTHORIZATION FOR RELEASE OF INFORMATION

This form is used to authorize Employee Benefit Systems (EBS) to disclose protected health information at the request of the individual.

1. Individual Authorizing Disclosure

Name: _____
Address: _____
City, State, Zip Code: _____
Telephone: _____
E-Mail: _____
Social Security Number: _____

2. Personal Representative

Name: _____
Address: _____
City, State, Zip Code: _____
Telephone: _____
E-Mail: _____

I hereby authorize the use or disclosure of my individually identifiable health information as described below.

- All my claims or inquires for health care benefits on and after the effective date of this appointment.
- My inquiries and claims for health care benefits with the dates of service: _____
- All inquires and claims for health care benefits for the following minor dependent(s): _____
- My appeal of denied claim(s) with the date(s) of service: _____

This appointment is effective upon EBS's receipt of a fully completed and signed original or exact copy of this form.

3. Expiration

- Expire 30 days after termination of my health plan coverage, or upon settlement of claims incurred while covered.
- On specified date of: _____
- On occurrence of the following event (which must relate to the individual or to the purpose of the use and/or disclosure being authorized): _____



Other (please explain): _____

I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to EBS.

4. On Line Claims Access

- Allow my personal representative as outlined in Section 2 above access to view my claims (EOB's = Explanation of Benefits) on line. I understand that by choosing this option, my personal representative will be able to view all claims for all dates of service.
- No, I do not want to allow my personal representative as outlined in Section 2 above access to view my claims (EOB's – Explanation of Benefits) on line.

5. Signature

Individual's Signature (or Legal Guardian if applicable)

Signature Date Required

Print Name of Legal Guardian if applicable*

**If a legal guardian signs for an individual, a copy of the guardian appointment document must be submitted with this form.*

6. Send Completed Form To:

Via Mail Service

Employee Benefit Systems
Attention: Claims Administration
214 N. Main St.
Burlington, IA 52601
319-752-3200

Via E-Mail

contactus@ebs-tpa.com

Via Fax

319-753-6114