PHBP

c/o BeneSys Administrators
Mailing Address: P.O. Box 2340, West Covina, CA 91793
P-(626)-646-1078 | Toll Free-(855)-696-2909 | F-(626)-931-1368
E-Mail: staff@phbpbenefits.org | Website: www.phbp.org

HIPPA RELEASE FORM

Dear Member:

We are writing to you in regard to the Health Insurance Portability and Accountability Act (HIPAA), which now requires a release form to be on file in order for us to give information regarding your Producers' Health Benefits Plan account and eligibility status, to anyone other than yourself.

To this end, we have enclosed a release form that you need to complete and return to us to indicate who it is, other than yourself that we may discuss all aspects of your account with. Please note that as stated above, and in addition to, this form will allow us to discuss your health-related information, provisions of health care, and other identifying information such as social security and telephone number.

Please fill out this form in its entirety, and return the original to:

Producers' Health Benefits Plan
BeneSys Administrators
PO Box 2340
West Covina, CA 91793

If you have any questions regarding this form, please do not hesitate to contact us at the number above.

Very truly yours,

Producers' Health Benefits Plan

HEALTH INSURANCE PORTABILITY AND ACCOUNTABLITY ACT (HIPAA) RELEASE FORM

PHBP
Producers' Health Benefits Plan

I. Participant Information (please print)

LAST NAME:	FIRST NAME:	SOCIAL SECURITY NUMBER: ☐☐☐-☐☐-☐☐☐☐
ADDRESS:	CITY:	ST: ☐☐ ZIP: ☐☐☐☐☐
DATE OF BIRTH: ☐☐/☐☐/☐☐☐☐	HOME TELEPHONE NUMBER: (☐☐☐)-☐☐☐-☐☐☐☐	CELLULAR PHONE NUMBER: (☐☐☐)-☐☐☐-☐☐☐☐

II. Specific person authorized to receive and use the information

NAME:	RELATION TO PARTICIPANT:	NAME:	RELATION TO PARTICIPANT:
1.		2.	
3.		4.	
5.		6.	

III. Specific description of the information we may release (eligibility, work history, etc.)

IV. Right to revoke

I understand that I have the right to revoke this authorization at any time by notifying BeneSys Administrators in writing at PO Box 2340 West Covina, CA 91793. I understand that the revocation is only effective after it is received and logged. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation. I understand that after this information is disclosed, federal law might not protect it and the recipient might re-disclose it. I understand that I am entitled to receive a copy of this authorization.

Signature_____ Date_____