PHBP
Producers' Health Benefits Plan

c/o BeneSys Administrators, P.O. Box 2340
West Covina, CA 91793 | (323) 647-PHBP | www.phbp.org

Dear PHBP Participant, i

If you would like to grant permission to the PHBP to discuss your PHBP account, work history, eligibility, contact information, provisions of health care, or any other personal and/or identifying information, including social security number, with another person in addition to yourself, including a spouse or dependent, even if covered on this Plan, the Health Insurance Portability and Accountability Act (HIPPA) requires the Plan to have the following signed release form on file.

Please note you can limit the released information. For example, you may grant another access to your account but limit that access to issues relating to work history, eligibility, coverage dates, premium payment due dates, methods of making a payment to your account, etc.

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

Producers' Health Benefits Plan
BeneSys Administrators
P.O. 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.

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_____