EBS-RMSCO, Inc.
Employee Benefit Solutions

Authorization to Release Protected Health Information

Employer Name

Participant First Name | MI | Last Name

Address

City | State | Zip Code

Email Address

Social Security Number / Member ID | Phone Number

EBS-RMSCO, Inc. maintains a strict policy of adhering to state and federal regulations with regard to Protected Health Information (PHI). Generally, except as permitted by law, we cannot disclose your personal information to another person without your consent. By executing this form, you are authorizing EBS-RMSCO, Inc. to release your PHI to the persons or entities below (PHI includes information regarding your account and your claims).

Authorization

I hereby authorize the use or disclosure of my PHI to the following *(please print clearly)*:

1.

2.

3.

- Mail to EBS-RMSCO, Inc., FSA Dept. 30 Perinton Hills Mall, Fairport NY 14450 or fax to 877-256-7228.
- Call Customer Service with questions at 800-327-7130.
- Please be sure to provide your SSN or Member ID.

I understand that I have the right to revoke this authorization at any time, but that the following two exceptions apply to my right to revoke: (i) if EBS-RMSCO, Inc. has acted in reliance upon the authorization; and (ii) if the authorization was obtained as a condition of obtaining insurance and the insurer has the right to content a claim under the policy.

I also understand that (1) this authorization is voluntary and EBS-RMSCO, Inc. will not refuse payment, enrollment or eligibility for benefits based on my refusal to sign it; (ii) the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by privacy rules and regulations; and (iii) unless revoked earlier, this authorization is effective for release of information for the duration of my enrollment in the Plan.

To revoke, I must notify EBS-RMSCO, Inc. in writing.

Participant Signature

Date