Crosby Benefit Systems, Inc. (CBS)

AUTHORIZATION

To Use and Disclose Protected Health Information

Participant:

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

Participant Information:

Name: ____

Client/Company: ____

Address: (Home) ____

Date of Birth: ________________________

DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED:

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WHO IS AUTHORIZED TO USE OR DISCLOSE THE INFORMATION?

Crosby Benefit Systems, Inc.

Health Plan (Name of Insurance Carrier): _________________________

Dental Plan (Name of Insurance Carrier): _________________________

Vision Plan (Name of Insurance Carrier): _________________________

WHO IS AUTHORIZED TO RECEIVE THE INFORMATION ON YOUR BEHALF (ONE PERSON PER AUTHORIZATION) **PLEASE INCLUDE FULL NAME AND RELATIONSHIP**

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REASON THE INFORMATION WILL BE USED OR DISCLOSED

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Signature: __________________________________ Date: ____________________

If this authorization is signed by someone who is not the participant listed at the top of this form, provide a separate written description and/or a power of attorney letter to show the signer's authority to act for the participant.

Incomplete authorizations will not be processed.

This authorization will expire December 31, 2009.

It is the responsibility of the participant to re-authorize the individual listed above at the end of the authorization period.

Notice to Participant

You may revoke this authorization at any time. To revoke this authorization, send a written statement to the Crosby Benefits Privacy Official, 27 Christina Street, Suite 200 Newton, MA 02461. The statement must identify this authorization by referring to the date it was signed. The statement must include the date on which this authorization is no longer in force.

If you revoke this authorization, we may still use and disclose the information for the purposes listed above, if we have already taken action in reliance on this authorization. Also, if this authorization is to permit disclosure of information to an insurance company, in order for you to obtain insurance coverage, the insurance company may still have the legal right to use the information to contest a claim or to contest your coverage.

You do not have to sign this authorization to receive payment, to enroll in your company's health plan, or to be eligible for benefits, except:

- If this authorization is sought is for the purpose of determining your eligibility for benefits or enrollment, then you must authorize CBS to obtain the necessary information or the benefits or enrollment may be denied.
- If this authorization is sought is for the purpose of underwriting or risk rating determinations, then you must authorize CBS to obtain the necessary information or benefits or enrollment may be denied.
- Under Federal law, you do not have to authorize us to receive the private notes from counseling sessions, that are kept by a mental health professional, as a condition of payment, enrollment in a health plan, or eligibility for benefits.

Once your information is disclosed to the person or organization listed on the authorization, this information is *no longer* protected by the privacy requirements in HIPAA. The persons or organizations that receive your information because of this authorization may disclose this information to other people or organizations without your knowledge or consent.

Participant Reminder:

Upon expiration of this authorization, it is the responsibility of the participant to re-authorize the individual.

Incomplete Forms will not be processed.