Authorization for Disclosure of Protected Health Information

My protected health information is information about me, including information such as my name, address, social security number, date of birth and/or medical information. The information was used or created when I received health care or when payment was received for my health care. The information may include my past, present or future physical or mental health or condition.

Name:____ Member ID/SSN:_______________________________

Address:____ DOB:____

____ Telephone:____________________________________

____ Email:____

Group Name:____Plan Name:____________________________________

I hereby authorize The Lance Group Employee Benefit Specialists, LLC (located at Five Greentree Centre, Suite 104, Marlton, NJ 08053), and its affiliates to disclose and/or receive confidential information pertaining to the member/insured named above.

This release is for (please complete):

Carrier/Provider Name:____

Address:____

____

Phone:______________________________________ Fax:___________________________________

This release is for the purpose of (please check all that apply):

- ☐ Coordination of benefits
- ☐ Claim resolution
- ☐ Payment resolution
- ☐ Other:________________________________

The Lance Group agrees to maintain my protected health information in accordance with its privacy policy practices.

This authorization will expire on __________________ or on occurrence of the following event_______________________ which relates to the purpose of the use and/or disclosure being authorized. If no date is specified, this authorization will automatically expire in six (6) months from the date originated.

You may revoke this authorization at any time by providing written notification to The Lance Group Employee Benefit Specialists. Your revocation of this authorization will not affect any action we have taken before we receive your notice of revocation.

Signature:____

Printed Name:____

Date:____

Authorized Representative/Guardian (if under 18):____