Employer Name _____

ClaimLinx or Medical Cost Advocate
Protected Health Information Release Form

I hereby authorize the disclosure of protected health information about me and/or my family as described below:

1) The following specific person or class of persons or facility is authorized to make the requested use or disclosure.

2) The following person or class of persons may receive disclosure of protected health information about me and/or my family:

Any employee or representative of
ClaimLinx or Medical Cost Advocate

3) The specific information that should be disclosed is: As requested

4) I understand that the information used or disclosed may be subject to re-disclosure by ClaimLinx or Medical Cost Advocate or by the facility receiving it (i.e. hospitals, doctors, medical facility). In such cases, information will remain protected by federal privacy regulations governing the disclosure of protected health information by ClaimLinx or Medical Cost Advocate.

5) I may revoke this authorization by notifying ClaimLinx or Medical Cost Advocate in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

6) This authorization expires upon occurrence of the following event that relates to me and/or my family or to the purpose of the intended use or disclosure of information about me and/or my family: termination of relationship with ClaimLinx or Medical Cost Advocate.

_____ _____
Signature of Individual or Guardian Date of Signature

_____
Printed Name of the Above Signed

_____ _____
Phone Number

_____
Address

_____ _____
Date of Birth of the Above Signed Social Security Number

****SEND COMPLETED FORM TO CLAIMLINX****
EMAIL TO ENROLLMENTS@CLAIMLINX.COM OR FAX TO (800) 858-1913