bentegrity
Benefit Solutions with You In Mind

Standard Authorization Form to Use or Disclose
Protected Health Information (PHI)

Patient Information:

_____
Name

_____ _____
Date of Birth Alternate ID Number

_____ _____
Address City, State, Zip

_____
Area Code & Phone number

_____
Group Name and Group Number

Authorization and Purpose:

I request and authorize Bentegrity Solutions to disclose my protected health information as described below. **I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by the federal privacy regulations.**

_____
Persons/Organizations authorized to receive your information

_____ _____
Relationship Purpose

_____ _____ _____
Address City State & Zip

Release of Protected Health Information:

Health plan benefit information, claim information and all medical records. This form is valid 12 months from the date signed by our client.

_____ _____
Signature Date

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