# Authorization for Release of Protected Health Information

Chard Snyder is not permitted to discuss or provide to any person, including your spouse, any information concerning protected health information (PHI) under your benefit plan(s). Use this form to authorize sharing your information.

| **Company Information (PLEASE PRINT)** | | | |
|---|---|---|---|
| Company Name | | Division (if applicable) | |
| **Participant Information (PLEASE PRINT)** | | | |
| Last Name | | Primary Phone | |
| First Name | | Secondary Phone | |
| SSN / (or Alternate Employee ID) | Date of Birth (mm/dd/yyyy) | Email Address (For Account Notifications) | |
| Street Address | | | |
| City | | State | Zip |

| **Whose PHI May Be Shared** | | |
|---|---|---|
| Participant ☐ Covered dependents ☐ | | |
| *Covered dependents **over** the age of 18 must submit a separate authorization form.* | | |
| **Covered Dependent(s) Under the Age of 18** | | |
| Last Name | Last Name | Last Name |
| First Name | First Name | First Name |
| Date of Birth (mm/dd/yyyy) | Date of Birth (mm/dd/yyyy) | Date of Birth (mm/dd/yyyy) |
| SSN | SSN | SSN |

| **Individual or Organization Authorized to Receive/Discuss Protected Health Information** | | |
|---|---|---|
| Last Name | Primary Phone | |
| First Name | Secondary Phone | |
| Organization Name | Email Address (For Account Notifications) | |
| Street Address (Check if New Address ☐ ) | | |
| City | State | Zip |
| May receive PHI from ☐ All benefit plans ☐ Healthcare Flexible Spending Account ☐ Health Reimbursement Arrangement (HRA) | | |
| Purpose for which information may be disclosed: | | |
| Authorization expires: ☐ When my enrollment in the benefit plan ceases ☐ On the following date_____ | | |

**Certification** ☐ Participant ☐ Designated Authorized Representative (See form on back)

I certify that I have read and understand the following statements. This authorization is voluntary and I am not required to sign it to receive my health benefits. The information used or disclosed according to this authorization may be shared by the receiving individual or organization. I have the right to seek assurances from the individuals or organizations authorized to receive/discuss protected health information that they will not redisclose the information to any other party without my further authorization. Chard Snyder will not be held liable for any redisclosure of protected health information by such recipients. I may revoke this authorization at any time prior to its expiration date by notifying Chard Snyder in writing, but the revocation will not have any effect on any actions by Chard Snyder before the notice was received. I understand this authorization will expire as stated above and I will need to complete a new form to provide further authorization to access my protected health information.

| Signature | Date |
|---|---|

**SEND THIS FORM TO CHARD SNYDER**

Please submit this form to Chard Snyder by one of the two methods listed to the right

**Fax:** Local 513.459.9947 / Toll-Free 888.245.8452 ***(Please DO NOT include a Fax Cover Page)*** **Mail:** PO Box 2924, Fargo, ND 58108-2924

# Authorization for Release of Protected Health Information by Designated Authorized Representative

**Who is a Designated Authorized Representative**

If the participant or Covered Dependent over the age of 18 is unable to sign this form for any of the following reasons, the participant's legal representative must provide one of the following and complete the information below:

1. If the person is deceased, the legal representative must provide documentation that he or she is the executor or administrator of the participant's estate. We may not rely on a durable power of attorney, advance directive, guardianship or conservatorship papers after the death of the person, as the papers are not valid after death.
2. If the person is incapacitated and, as a result, a legal representative needs to act on behalf of the person, submit this completed authorization form and include the legal documentation showing who the legal representative is. Legal documentation includes durable power of attorney, guardianship or conservatorship papers.

| **Designated Authorized Representative** | | |
|---|---|---|
| First Name | Last Name | |
| Primary Phone | Email Address | |
| Street Address | | |
| City | State | ZIP Code |

**Legal Representative's Relationship to Participant**

| | |
|---|---|
| ☐ Power of Attorney | ☐ Executor or Administrator of Estate |
| ☐ Legal Guardian | ☐ Other_____ |

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