Authorization to Use/Disclose Protected Health Information

This Authorization Must Be Completed In Full For It To Be Valid.

Instructions: This form authorizes Consumer Choice Plans, Inc. and Insurance Consulting Group, Inc. to obtain medical information in relation to your health insurance, dental insurance, and medical spending account plan. This form authorizes the release of information regarding your health insurance, dental insurance, and medical spending account plan. This authorization does not provide your "Authorized Representative" with any authority; either implied or direct, over any direct care decisions.

Please attach a copy of your health insurance card.

A. Participant Information

Member:____ID#______________________________

Social Security Number_____________________________ Date of Birth________________________

Address____

City__________________________________State__________________________Zip___________

Day Telephone Number ___________________________E-mail Address________________________

B. Type of Information

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

C. Authorized Use and/or Disclosure

Intended Use or Disclosure:

I understand that your general policy is not to disclose my personal health information to other parties, except those directly involved in my care, without my written authorization or as permitted or required by law. For this reason, I authorize you to discuss and disclose my personal health information to the person(s) named below for the purpose of assisting with, or facilitating, the coordination or payment of my health benefits. I also understand that if my Authorized Representative is not a health care provider or another entity subject to federal or applicable state privacy laws, my personal health information may no longer be protected by those privacy laws and my Authorized Representative may further disclose my personal health information without my authorization. I acknowledge that my authorization is voluntary.

D. Authorized Representative #1

Consumer Choice Plans, 100 Fountain Avenue, Suite 100, P. O. Box 2870, Paducah, KY 42002-2870. Telephone Number: 1-270-210-9552. Relationship: Claims Facilitator.

Signature______________________________ Date_____________________________

E. Authorized Representative #2

Insurance Consulting Group, Inc., 4735 Spottswood, #204, Memphis, TN 38117. Telephone Number: 1-901-795-8444. Relationship: Claims Facilitator.

Signature______________________________ Date_____________________________

G. Restrictions

If you want to restrict the information that the Authorized Representative may receive, indicate those restrictions below.

H. Expiration and Revocation

This authorization will automatically terminate 12 months from the date of signature below.

I understand that I have the right to revoke or end this authorization at any time. I understand that if I do not wish the person(s) named in Section D to remain my Authorized Representative, I must revoke this authorization in writing by giving written notice of my decision to Consumer Choice Plans at P. O. Box 2870, Paducah, KY 42002-2870. I understand that my revocation of this authorization will not affect any action that you have taken, or any information that you have already released, based upon this authorization before you actually receive my request to revoke it.

I further understand that access to my personal information on my health insurance company's web site will be sought by my authorized representative in order to substantiate my claims. Thus my authorized representative will assign to me a password and user id unless I already have a password and user id. My user id is ______________________, my password is _______________________.

Signature______________________________ Date_____________________________