Authorization To Release Information

INSTRUCTIONS: You must complete all information below. If incomplete, this authorization will be returned. If you have any questions or need assistance completing this form, please contact Northeast Benefits Management, LLC at (802) 865-0239. This form consists of 2 pages.

Section 1. Member Information

Participant's Name:_____ Date of Birth: _____

Company Name:_____

Telephone: _____ E-mail address: _____

Address: _____
Number and Street City State Zip Code

Section 2. Important Information about this Authorization to Release Information

Purpose - I authorize Northeast Benefits Management, LLC (NBM) to give information regarding my Flexible Spending Account and/or Health Reimbursement Arrangement claim to the authorized person(s) named in Section 3. I have requested this information to be given to the authorized person(s) for the purpose of responding to an inquiry regarding my health benefits.

Indemnity - I hereby release NBM, its subsidiaries, affiliates, employees, officers and agents from any and all liability associated with the release of such information and records to the authorized person, and further agree to indemnify and hold NBM harmless, and defend NBM in court, if necessary, from any claims arising out of any release of information pursuant to this authorization.

Voluntary Authorization - This authorization is voluntary; NBM will not condition my enrollment, eligibility for benefits or payment of claims on giving this authorization.

Re-disclosure of Information - I understand that the authorized person(s) who receives my protected health information under this authorization may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws.

Section 3. Authorized Person(s) - Authorization may only be granted to an individual not to an organization.

Provide the information below for each person that is authorized to receive your protected health information identified above. Please include a complete address and specify the relationship to the patient. Please print.

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone: _____
Relationship to Participant: _____

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone: _____
Relationship to Participant: _____

Section 4. Expiration

Unless revoked, this authorization is valid from the date of my signature until the date I am no longer a Participant of NBM or upon the date written below (if any), whichever occurs first. This authorization will automatically terminate upon my death.
This authorization shall terminate on (specify date, if applicable) _____.

Section 5. Revocation

I understand that I may revoke this authorization at any time by mailing ***written*** notice of my revocation to Northeast Benefits Management ATTN: Claims Manager at PO Box 2363 South Burlington, VT 05407-2363.

Section 6. Signature

I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to NBM. I understand that, by signing this form, I am confirming my authorization NBM, its subsidiaries, affiliates, employees, officers and agents may use and/or disclose the protected health information described in this form to the authorized person(s) named above.

Participant's Signature: _____ Date: _____

Please scan and email,
mail or fax to:

Northeast Benefits Management, LLC
PO Box 2363
South Burlington, VT 05407-2363
Scan and email: info@nbmus.com
efax: (802) 304-1009

NBM
Employee Benefits Simplified