

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

I, _____ (Name), hereby authorize the use or disclosure of my Protected Health Information (PHI) as described in this authorization.

Name of entity authorized to provide the Protected Health Information:

Entity authorized to receive and use the Protected Health Information:

**Commerce Benefits Group
Claims Department
P.O. Box 900
Elyria, OH 44036**

The specific information that may be released: Complete medical records for claim adjudication and payment.

Right to Revoke: I understand that I have the right to revoke this authorization at any time by notifying Sherri Delestathis (HIPAA Privacy Officer) in writing at P.O. Box 900, Elyria, Ohio 44036. I understand that the revocation is only effective after it is received and logged by the HIPAA Privacy Officer. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

I understand that after this information is disclosed, federal law might not protect it and the recipient might re-disclose it.

I understand that I am entitled to receive a copy of this authorization.

I understand that this authorization will terminate when my coverage under the Plan terminates.

Signature: _____ Date: _____

Print Name: _____

«Social»
«Company»

If authorization is being completed by Personal Representative:

Signature: _____ Date: _____

If Personal Representative executes this form, the Representative warrants that he or she has the authority to sign this form for the individual named above.