

## AUTHORIZATION INSTRUCTION SHEET

As a result of the Health Insurance Portability and Accountability Act of 1996, as amended (“HIPAA”), EBMS is no longer able to access a patient’s protected health information from your provider in some cases. If you wish to allow EBMS to have access to your protected health information please execute the enclosed Authorization and return it to EBMS.

In executing the Authorization, you will need to do the following:

1. Insert your plan name and address where indicated;
2. In Paragraph #3 you can insert the type of information to be disclosed. This can be as broad as you wish. It can say “any and all protected health information,” or it can be more specific.; and
3. Sign and date the Authorization.

Once you have executed the document, you can return the signed document to EBMS at P.O. Box 21367, Billings, MT 59104-1367, or you can fax it to (406) 652-5380 attention Brenna Yarina

If you have any questions or concerns, please do not hesitate to contact me at (800) 777-3575 ext. 1428.

Thank you.

Sincerely,

Brenna Yarina  
Corporate Legal Assistant

**AUTHORIZATION FOR RELEASE  
OF PROTECTED HEALTH INFORMATION**

**Terms used in this Authorization:**

The Individual: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

The Third Party Administrator: Employee Benefit Management Services, Inc. (EBMS)  
Address: P.O. Box 21367  
Billings, MT 59104-1367

The Plan(s): \_\_\_\_\_

This Authorization is provided in accordance with the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Standards") issued under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA").

I, \_\_\_\_\_, am a participant in the above referenced Plan(s) and hereby authorize the use or disclosure of my protected health information as described in this Authorization.

1. Specific person(s)/organization authorized to provide the information.

**Any and all Health Care Providers**

2. Specific person(s)/organization authorized to receive and use the information.

**Employee Benefit Management Services, Inc. (EBMS)**

3. Specific description of the information to be used and/or disclosed.

\_\_\_\_\_

I, \_\_\_\_\_, hereby understand the following:

4. Right to revoke: I understand that I have the right to revoke this Authorization at any time by notifying the Third Party Administrator, in writing, at the appropriate address set forth above. I understand that the revocation is only effective after it is received and logged by the Third Party Administrator. I understand that I cannot revoke this authorization to the extent that action has been taken in reliance of this authorization (for example, any use or disclosure made prior to the revocation under this Authorization will not be affected by the revocation).

5. I understand that after the information that is the subject of this Authorization is used or disclosed, the Privacy Standards may not protect it and the recipient may redisclose it.

6. I understand that this Authorization is not required for the Plan(s) to use or disclose this information for purposes of treatment, payment or health care operations, or if the use or disclosure is otherwise permitted by the Privacy Standards, and that any revocation of this Authorization will have no effect on such uses or disclosures.

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

8. I understand that this Authorization will automatically renew at the beginning of each calendar year unless otherwise revoked pursuant to the provisions outlined in paragraph 4 above. I further understand that this Authorization will permanently expire when the Individual's coverage under the Plan(s) terminates, or when the Individual has no further claims for which payment is requested under the Plan(s), whichever is later.

\_\_\_\_\_  
Date Individual

If a personal representative executes this form, that representative warrants that he or she has authority to sign this form on the Individual's behalf on the basis of \_\_\_\_\_.

Documentation Required (POA/Guardianship/etc.)

\_\_\_\_\_  
Date Personal Representative