AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

This authorization is made pursuant to the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). By signing this form in Section 5 below, I authorize Vision Benefits of America, Inc. and Vision Benefits of America II, Inc., (together referred to as "VBA"), to release my individually identified health information described below in Section 1 to the person or entity named in Section 2. I understand that this authorization is voluntary, that I may obtain a copy of this form, and that I may revoke it at any time by submitting my revocation in writing to VBA.

Member Full Name: _____

Date of Birth: _____ **Telephone Number:** _____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Last 4 Digits of Policyholder's SSN: _____ **Policyholder's Date of Birth:** _____

By signing this form, I authorize VBA to release my individually identified health information described below to the person or organization named in Section 2.

1. Description of Protected Health Information to be Released, Including Dates:

_____

_____

_____

2. Name of Person(s) or Organization Authorized to Receive Information:

Name: _____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Telephone Number: _____

I understand that any personal health information or other information released to the person or organization identified above may be re-disclosed by such person/organization and may no longer be protected by federal privacy regulations.

3. Purpose of Disclosure

Please check:

☐ **At the request of the member; or**

☐ **Other (please explain)** _____

_____

_____

4. Expiration Date or Expiration Event

This authorization to release information is valid from the date of my/my representative's signature below and shall expire the earlier of _____ *[insert date/event upon which this authorization expires]* OR upon the date of expiration of my group health care plan with VBA.

I understand that I have the right to revoke this authorization at any time as detailed in VBA's Privacy Notice. I understand that my revocation must be in writing. I also understand that my revocation of this authorization will not affect any action that VBA has taken, or any information it has already released, based upon this authorization before VBA has actually received my written request to revoke it.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits, enrollment, payment for, or coverage of, services.

5. Signature of Member and Date

_____ _____

Signature of member or member's authorized representative **Date**

Printed name of member's representative: _____

Relationship to member, including authority for status as representative *(Signers other than the member or his/her natural parent must present legal documentation such as a power of attorney, living will, guardianship papers, etc. that authorizes them to act on the individual's behalf with respect to this authorization):*

_____

_____

_____

_____

RETURN COMPLETED AUTHORIZATION FORM TO:

VBA Compliance Department
400 Lydia Street, Suite 300
Carnegie, PA 15106
Fax: 412-881-4898