VIA BENEFITS™

Authorization to Release Protected Information

What I Need To Do:

- ☐ **Approve or Cancel Authorization** of protected information by completing sections A, B, C, Approve or Cancel Authorization and Signature Release
- ☐ Prepare supporting documentation
- ☐ Sign and date form in Signature Release
- ☐ Email, mail or fax your completed form and supporting documentation

What I Need To Know:

What protected information will be released?

This form authorizes Via Benefits to release, at your request, your personal information to another person or organization that you designate. Personal information may include, but is not limited to the following: reimbursement request information (including provider name, substantiation and dollar amount), reimbursement information, Explanation of Payment (EOP), receipt request letters, premium amounts, insurance carrier name, web access, debit card (if applicable), bank account information and general plan inquiries. Once information is disclosed pursuant to this authorization, the federal privacy standards (45 C.F.R. Part 164) protecting health information may not apply to the authorized representative of the information and, therefore, may not prohibit the authorized representative from re-disclosing it.

Who can complete the form if the participant is unable or incapacitated?

If the participant is unable to complete this form, the participant's Legal Representative can complete and return the form with the legal documentation of representation, such as a court order Durable Power of Attorney, Guardianship or Conservatorship.

Who can complete the form if the participant is deceased?

For deceased participants, this form should be completed by the Legal Representative (i.e., executor or administrator) of the participant's estate and must be accompanied by proof that the individual requesting the release is the legal representative of the estate. Some examples of documentation we prefer to receive include: Executor of Estate, Administrator of Estate, Court documents, Trust documents, or signed Last Will and Testament documents. Please make sure to include all pages of the document.

Will any designations remain after a participant's death?

Please be aware that Via Benefits' policy will allow a valid Durable Power of Attorney or Guardianship or Conservatorship to remain in effect, including after death, until it is revoked, cancelled or changed.

Note: This form is not to be used in order for providers to file billing, reimbursement request or Explanation of Payment (EOP) information or documentation. Authorized representative must provide all information listed in Section A when contacting Via Benefits to access participant account.

- Email to: ARDR@viabenefits.com
- Mail to: Via Benefits
P.O. Box 981155
El Paso, TX 79998-1155
- Fax to: 1-866-886-0879
Total pages:
- Phone number: 1-833-981-1280

SECTION A - Identify Participant Information: Individual whose information will be released.

Participant Name:		
Address:		
City:	State:	ZIP Code:
Phone Number:	Email:	
Social Security Number:	Date of Birth:	
Former Employer:		

SECTION B - Grant Privileges: Via Benefits can administer two levels of privileges.

Select One

☐ **Grant Full Account Privileges** (equivalent to that of the participant, allows the authorized representative to receive all account information, submit reimbursement request and required documentation and make changes to the account such as setting web username and password, requesting debit cards, if applicable and changing bank information) until changed or canceled.

☐ **Grant Limited Account Privileges** (for informational purposes only, will not allow authorized representative to make or authorize changes for account) until changed or canceled.

SECTION C - Authorized Representative Information: Authorized person to receive protected information. A separate form must be completed for each authorized person.

Authorized Representative Name:		
Address:		
City:	State:	ZIP Code:
Phone Number:	Email:	
Relationship to Participant:		

Approve or Cancel Authorization:

Select One

☐ **By signing below, I authorize** the release of my protected information to the above named authorized representative, which may include protected health information, as described above, to the authorized representative named above, until I cancel this authorization in writing. I understand this authorization is voluntary. My treatment, payment, health plan enrollment, or eligibility for benefits will not be affected if I do not sign this form. I understand Via Benefits cannot control how the authorized representative uses or shares the information, and laws protecting its confidentiality at Via Benefits may or may not protect this information once it has been released to the authorized representative. Revoking this authorization will not affect any actions taken before the receipt of the written request.

☐ **By signing below, I cancel** the authorization to release my protected information for the below authorized representative.

Signature Release:

Participant Name:	
Participant Signature:	Date: