HIPAA AUTHORIZATION FOR RELEASE OF INFORMATION

I, as the Patient named below (or as the Personal Representative of the Patient named below), hereby authorize the use or disclosure of my individually identifiable health information ("Protected Health Information" or "PHI"), including secure web access to claims data (if provided by the plan), with respect to the SISC Health and Welfare Benefit Plan as described below.

Patient name: _____ ID Number: _____
Patient DOB: _____

Persons/organization providing the information: Person/organization receiving the information:
IEC Group, Inc. dba AmeriBen/IEC Group

Type of PHI to be disclosed: [*e.g., claim date of service, claim dollar amount, treating provider name, accumulator information, claim type, network contractual adjustment amount, ineligible amount, co-payment amount, deductible amount, covered expenses, payment percentage, claim payment amount.*]

Purpose(s) to which disclosure of PHI will be limited: [*e.g., claims processing for the benefit of the participant in the form of; claim status; claim payment status, claim appeal status and decision, claim processing details, plan benefit information.*]

I further understand and agree:

1. This Authorization will expire 12 months after the termination of my participation in the Plan
2. I may revoke this Authorization at any time by notifying the providing person/organization in writing;
3. I may see and copy the information described on this form if I ask for it;
4. I am not required to sign this form to enroll in, or receive my health care benefits under, the Plan; and
5. The information that is used or disclosed under this Authorization may be re-disclosed by the receiving entities, but only for the specific purposes authorized.

I certify that I have read and understand this Authorization, and that the information in it is true and correct.

Signature of Patient (as listed above) or Personal Representative_____
Date _____

Termination date of this Authorization (if different than termination date of Plan) _____

PERSONAL REPRESENTATIVE (complete only if applicable): I am signing this Authorization on behalf of the Patient as the Patient's Personal Representative, and I certify that: (1) I have legal authority to act on behalf of the Patient as it relates to healthcare decisions; (2) the information in this Authorization is true and correct, and (3) the information provided below to verify my identity is true and correct.

Printed name of personal representative: _____
Personal representative's date of birth: _____
Personal representative's relationship to the patient: _____

SIGNING THIS AUTHORIZATION IS NOT A PREREQUISITE TO YOUR PARTICIPATION IN THE SISC Health and Welfare Benefit Plan