HIPAA Release Form

AMERICAN BENEFIT ADMINISTRATORS

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION
Primary Account Holder must complete this form to authorize the release of protected health information to a third party.

PRIMARY ACCOUNT HOLDER INFORMATION	
First Name	**Last Name**
Email Address:	**Phone:**
Mailing Address:	

HIPAA RELEASE (TO BE COMPLETED BY PRIMARY ACCOUNT HOLDER)

My protected health information is individually identifiable health information, including demographic information collected from me or created or received by a health plan, my employer, or a health care clearinghouse, and relates to: (i) my past, present or future physical or mental health condition; (ii) the provision of the health care to me; or (iii) the past, present or future payment for the provision of health care to me.

In accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA), I, the undersigned, grant permission to American Benefit Administrators, LLC to disclose protected health information (as defined in HIPAA) to the following person or persons:

____

Authorized Person(s)

Purpose of authorization:

- ☐ At my request
- ☐ Family member assisting with health care
- ☐ Other: ______________________________

This release will remain in effect until the closure of the account. In addition, I may revoke this Release at any time by notifying American Benefit Administrators of the revocation in writing.

If at any time you need to alter this release form, please contact American Benefit Administrators at (866) 742-4900.

Signature:	**Date:**

Please return this form by mail, fax, or email to:

American Benefit Administrators
Attn: Customer Service Team
PO Box 380844
Birmingham, AL 35238
Fax (866) 734-4777
Email: support@americanbenefitadministrators.com