Authorization for Release of Health Information

I, ___________________________________, (Employee or Patient Name) hereby authorize _________________________________ (name of Authorized Representative) to discuss and receive my health information, on my behalf, as described in this authorization.

The above named Authorized Representative is acting on my behalf in the resolution of any claims issues that I may have.

Right to Revoke: I understand that I have the right to revoke this authorization at any time by notifying Michigan Employee Benefit Services, Inc. (MEBS), in writing, at:

Claims Manager
3809 Lake Eastbrook Boulevard
Grand Rapids, Michigan 49546

I understand that the revocation is only effective after it is received and logged by MEBS. I understand that any use or disclosure made prior to the revocation under this authorization will be not be affected by a revocation.

I understand that after this information is disclosed, federal law might not protect it and the recipient might redisclose it.

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

I understand that this authorization will expire when my employment with my Employer terminates.

________________________________   ____________________
Signature of Employee/Patient   Date