EBS can help:

Employee Benefit Systems Third Party Administration Services

MEMBER AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize: Employee Benefit Systems (EBS), Third Party Administrator of employer benefit plans whose principal office is located at 214 North Main Street, PO Box 1053, Burlington, IA 52601;

To disclose from the records of:
Name: _____
Address: _____
City, State, Zip Code: _____
Birthdate: _____
Telephone: _____
E-Mail: _____
Social Security Number: _____

To disclose to: _____

The following information may be disclosed: _____
(Any and all medical information)
_____

For the purpose of: _____
(If requested by the participant simply state "At the request of the Participant")

I understand this will include information relating to (check and initial if applicable)
☐__ Acquired immunodeficiency syndrome (AIDS) human immunodeficiency virus (HIV) infection
☐__ Behavioral health service / psychiatric care
☐__ Treatment of alcohol and /or drug abuse

Affirmation of Release:
I give EBS permission to release only the information I have selected on this form to the individual(s) or agency(s) I have named. I understand that this authorization is valid up to the expiration date stated below and I may refuse to sign this authorization or revoke this authorization at any time by contacting EBS. Any revocation or refusal to sign this authorization will not affect my ability to obtain treatment or payment or my eligibility for benefits. The revocation will take effect on the day it is received by EBS in writing. I further understand that if the person or entity that receives the above specified information is not a health care provider, health plan, or health care clearinghouse covered by the federal privacy regulations or a business associate of these entities, the information described above may be re-disclosed and no longer protected by the regulations. This authorization will expire upon termination of my health plan coverage, or upon settlement of claims incurred while covered, unless revoked or an earlier date or event is entered.
Expiration date: _____

_____ _____
Signature of participant or Representative & Relationship if applicable Date Signed

Send Completed Form To:
Email: gatewaysupport@ebs-tpa.com
Fax: 319-758-8561

Contact Us