Authorization for Release of Information

I. Information about the Use or Disclosure

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information.

Name: _____ Employer: _____

Persons/organizations authorized to provide the information: **csONE Benefit Solutions**

☐ COBRA Compliance Department ☐ Flexible Spending Department

Persons/organizations authorized to receive the information: _____

Specific description of information to be used or disclosed (including date(s)): _____

Specific purpose of the disclosure: _____

Expiration: _____

II. Important Information about Your Rights

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing, but the revocation will not have any effect on any actions the entity took before it received the revocation.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).
- The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity. I have the right to see assurances from the above-named persons/organizations authorized to receive the information that they will not redisclose the information to any other party without my further authorization.

III. Signature of Individual or Individual's Representative

X_____ _____

Signature of Individual or Individual's Representative Date:

Printed name of the Individual's personal representative: _____

Relationship to the Individual, including authority for status as representative: _____

Please Note: YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.