PO Box 1014
Charleston, WV 25324-1014
844-552-7805
healthsmart.com/nysut

Authorization for Release of Protected Health Information

By completing this form you are authorizing HealthSmart Benefit Solutions to disclose your Personal Health Information to the individual or entity (your "Personal Representative") identified by you below. This designation is voluntary and in no way affects benefits, claims processing and payment or eligibility status.

Participant's Information

_____ _____ _____
Participant's Name Date of Birth NYSUT ID Number

Street Address _____

City, State, Zip Code _____

Types of Information
HealthSmart Benefit Solutions may discuss or release Personal Health Information (PHI) to my Personal Representative regarding the following information: eligibility, payment status, benefits, claims, medical information used to make payment decisions, providers, appeals and complaints about my health insurance coverage through HealthSmart Benefit Solutions.

Authorized Use and/or Disclosure
I authorize HealthSmart Benefit Solutions to obtain and/or release PHI to the person(s) named as my Personal Representative for the purpose of assisting with or facilitating the coordination or payment of my health plan benefits. I also understand that if my Personal Representative is not a healthcare provider, or other person subject to federal privacy laws, my PHI may no longer be protected by those privacy laws and may be subject to re-disclosure by my Personal Representative. HealthSmart Benefit Solutions is not responsible should my Personal Representative further disclose my protected PHI. I further understand that I have the right to limit the information that HealthSmart Benefit Solutions releases under this authorization. Limitations for disclosure are identified below. By leaving this section blank I am creating no limitation on disclosure of PHI.

Disclosure Limitations: _____

Expiration and Revocation
This authorization to release information to my Personal Representative(s) will automatically expire at the end of my group's plan year. I understand that I may revoke this authorization at any time by giving written notice to HealthSmart Benefit Solutions. Revocation will not affect any action that HealthSmart Benefit Solutions has taken, or any information that has already been released based upon prior authorization.

Designation of Personal Representative(s)

_____ _____
Name of Authorized Person Relationship to Participant

_____ _____
Name of Authorized Person Relationship to Participant

Signature of Authorization
I, the undersigned, do hereby swear that I am the above mentioned participant. I have read and understand the content of this Personal Representative Form. My signed authorization and submission to HealthSmart Benefit Solutions is voluntary and I acknowledge that the information released may include protected and individually identifiable information about me.

_____ _____
Signature of Participant Date

If you have any questions regarding this form, please contact us at 844-552-7805.