MERP Administration Services, Inc.
PO Box 4826, Greenwood Village, CO 80155

HIPAA PRIVACY
AUTHORIZATION FOR RELEASE OF INFORMATION

Last Name:	First Name:	Middle Initial:
Address:	Social Security Number:	Date of Birth:
Email address:		

Person/Organization Providing the Information 45 C.F.R. 164.508(c)(ii)	Person/Organization to Receive the Information 45 C.F.R. 164.508 (c)(iii)
	MERP Administration Services, Inc. d/b/a EZMERP

Description of the Information to be Released

The purpose of this release is to confer authority to, give to, or otherwise authorize MERP Administration Services, Inc., through its agents (claims processors), the ability to access my personal information regarding the payment of health insurance claims on my employer's group health insurance plan. To wit, I authorize MERP Administration Services, Inc. to access my online Explanations of Benefits (EOBs) from the insurance company for the purpose of further establishing benefits that may be due to me from the MERP plan established by my employer.

☐ Yes I wish to use this service ☐ No I do not elect to use this service

I authorize the release, disclosure and re-disclosure of:

1. All medical records, bills, information and/or opinions, without limitation, including all registration sheets, discharge summaries, ER records, H&P, consults, progress notes, discharge instructions, lab results, radiology results, EKG/cardiology testing results, operative reports, implant information, pathology reports, medication lists, imaging studies, behavioral health information, substance abuse information, human immunodeficiency virus (HIV) information, all information relating to personal and sensitive documents, all information including concerning all medical, psychological, psychiatric conditions, treatment tests, diagnosis and/or opinions, drug tests, screenings and/or results and diseases of any nature.
2. All insurance information, if and when two or more of the following policies are related to the processing of claims for the stated MERP plan, including the release and disclosure of all health insurance information and policies, automobile insurance information and policies, homeowner's insurance information and policies, including all policy endorsements, declarations sheets, applications, waivers, elections, underwriting file, claims file, statements, photographs, medical files, medical payment schedules and investigations.
3. All information from all entities which may have potential liens with regard to the subject litigation, including all information and files relating to welfare, Medicare, Medicaid, public assistance, workers compensation and/or self funded employee welfare benefit plans to which I belong within the meaning of ERISA, 29 U.S.C. 1001, et seq., including the disclosure of all relevant portions documenting the ERISA plan, evidence that the ERISA plan is fully self funded and all information relating to any and all subrogation liens.

MERP Administration Services, Inc.
PO Box 4826, Greenwood Village, CO 8015

Description of Each Purpose for the Use or Release of the information (Provide a detailed description of the activity for which the information will be used) (45 C.F.R. 164.508(c)(iv):
This authorization will be used for processing eligible claims under my primary insurance plan with my employer for the purpose of being reimbursed by the MERP plan established for this plan.
Will the health plan or provider receive money for the release of this information? (45 C.F.R. 164.508 (a)(3))
☐ Yes ☐ No

Unless otherwise revoked, this authorization for the release of the above information to the above named persons/organizations will expire at the conclusion of the administration agreement that exists between my employer and MERP Administration Services, Inc., or for the period reasonably needed to complete and update the request, whichever date is later. (45 C.F.R. 164.508 (c)(v))

I understand:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed. I understand that this authorization is voluntary (45 C.F.R. 164.508 (c)(2)(i))
- I have the right to revoke this authorization by sending a notice stopping this authorization to the medical provider listed above. The authorization will stop on the date my request is received (45 C.F.R. 164.508(c)(2)(ii))
- I understand the Notice of Privacy Practices provides instructions should I choose to revoke my authorization and I understand that a revocation does not apply to information already released in response to this authorization (45 C.F.R. 164.508 (c)(ii))
- I understand if the organization I have authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations (45 C.F.R. 164.508(c)(2)(iii))
- I understand I have the right to receive a copy of this authorization.

Signature:

X____ Date:________________________________

If executed by a parent or representative, please state relationship and/or authority to execute the above request:

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I have set up my own username and password with my health provider and supply it here for EZMERP usage.	I have not set up my username and password, therefore I give my consent for EZMERP to set up my account and notify me via secure mail.
______________________________User Name	Printed Name_________________________________
______________________________Password	Signed___________________________ Date________