Risk Management

501 North Thompson, Suite 202
Conroe, Texas 77301
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H.I.P.A.A. FAX 936/538-8169

To: Montgomery County Employee Benefit Plan H.I.P.A.A. Privacy Officer

I, _____, ☐ employee or ☐ participating eligible dependent, authorize Montgomery County Risk Management employees to access the following benefits,

☐ Medical ☐ Vision ☐ Dental ☐ Group life Insurance ☐AD&D

in regards to types of coverage and questions relating to plan document provisions and claims for the following dates of service:

_____

Medical information/Explanation of Benefits are not filed in the Risk Management Department. After resolution, medical information will be shredded. Be sure to keep your original paperwork for your files.

Doctors: _____
Facilities: _____

☐ I also give my permission to discuss the information with any of the listed above with the following individuals:

_____Relationship _____
_____Relationship _____
_____Relationship _____

Employee or a participating eligible Dependent

_____Social Security # _____
Print Name

_____Date _____
Signature

Witnessed by _____Date _____

Print Name _____

1) Right to revoke: I understand that I have the right to revoke this authorization at any time by notifying Montgomery County Employee Benefit Plan in writing at the Risk Management Department, 501 N. Thompson, Suite 202; Conroe, TX 77301. I understand that the revocation is only effective after it is received and logged by the Risk Management Department on behalf of Montgomery County Employee Benefit Plan. **2**) I understand that after this information is disclosed, federal law might not protect it and the recipient might redisclose it. **3)** I understand that I am entitled to receive a copy of the authorization. **4**) I understand that this authorization will expire when my participation under the Montgomery County Employee Benefit Plan ends.