HIPAA Consent Form/Release of Information

As your benefits administrator, BRMS is committed to keeping your private health information secure. BRMS is compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a Federal law that restricts access to an individuals' private medical information. As part of our process of keeping your personal health information secure, BRMS will only speak to you directly regarding your health claims, unless you give BRMS written consent to speak with a representative of your choosing.

Enrollees and adult members who complete this HIPAA consent form may designate an individual such as a spouse, parent, or adult child, to speak with a BRMS representative regarding their claim information. If you would like to give HIPAA consent to a designated individual, please complete this form.

SECTION 1: MEMBER INFORMATION

BRMS MEMBER NAME	**SOCIAL SECURITY NUMBER**
EMPLOYER NAME	**E-MAIL ADDRESS**
BRMS MEMBER IDENTIFICATION (ID) NUMBER	**BRMS PLAN NUMBER (listed on identification card):**

SECTION 2: MEMBER CONSENT

I hereby give consent to BRMS to use and disclose my protected health information for the purpose of payment of my claims, as defined by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 to the following party/individual:

NAME OF INDIVIDUAL/PARTY	**RELATIONSHIP/ASSOCIATION**

I further understand that the above-named individual may only receive claims payment information for the following dependents *(if applicable)*:

DEPENDENT NAME	**RELATIONSHIP TO MEMBER**

Date in which this consent will terminate (choose one):

- ☐ December 31 of the current calendar year
- ☐ Specific Date (MM/DD/YY): _____
- ☐ Specific Event: _____

SECTION 3: REQUIRED SIGNATURE

I understand that, at any time, I have the right to revoke this consent provided that I do so in writing to BRMS at the address listed below. I further understand that any use or disclosure that occurred prior to the date I revoked my consent, including claim payments, that have not been completed, is not affected by my revocation.

BRMS MEMBER SIGNATURE	**DATE**

Please complete and send via *one* of the following:

MAIL:
BRMS
Attn: Customer Support
80 Iron Point Circle, Suite 200
Folsom, CA 95630

FAX: (916) 467.1401

For questions about your Dignity Health Central Coast EPO Medical Plan, please contact member services at (866) 755-6974.