



P.O. Box 4982  
Syracuse, NY 13221  
Phone: 1-800-828-0078

Dear Subscriber:

Subject: Release of Information

It is the policy of EBS-RMSCO, Inc. to release information in accordance with state and federal regulations.

A contract holder, and their covered dependent(s), may obtain information regarding their coverage and an authorization to release information is not required. All other requests received require written authorization from the subscriber prior to the release.

To better serve you, we have attached an "Authorization to Release Information." Please complete, sign and return the authorization for our records. Failure to return the completed authorization will limit our ability to serve you in a timely manner.

Sincerely,  
Customer Service Representative  
EBS-RMSCO, Inc.

## Authorization To Release Information

Subscriber Name: \_\_\_\_\_

EBS Line of Business: Flex / TPA / Premium Billing / COBRA

Employer Name: \_\_\_\_\_

Identification Number: \_\_\_\_\_

I hereby authorize EBS-RMSCO, Inc. to release the following information upon request:

\_\_\_\_\_ Contract information (type of contract(s), effective date(s), family or individual waiver, rider, etc...)

\_\_\_\_\_ Benefit information (services covered and/or excluded)

\_\_\_\_\_ Claim information (receipt, date of service, provider, charge, allowance, denial reason, patient, etc...)

Please provide the information I have authorized to be **released to**:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Information may be released for the following individuals listed on the contract:

\_\_\_\_\_  
\_\_\_\_\_

I understand that I have the right to revoke this authorization, in writing, at any time. (Requests to revoke an authorization must be directed to EBS-RMSCO, Inc.) I understand that the two exceptions to the right to revoke are: (1) where EBS-RMSCO, Inc. has acted in reliance upon the authorization, (2) if the authorization was obtained as a condition of obtaining insurance coverage and other law provides the insurer with the right to contest a claim under the policy. I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the privacy regulations. I also understand that this authorization is effective for release of information: (1) Flex – until the end of the plan year, (2) Others – for the duration of my enrollment in the plan. I further understand that this authorization is voluntary and EBS-RMSCO, Inc. will not refuse payment, enrollment or eligibility of benefits based on my refusal to sign. I hereby authorize the release of information as specified.

Subscriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please mail to: EBS-RMSCO, Inc., PO Box 4982, Syracuse NY 13221