MERITAIN HEALTH
An Aetna Company

Client Name _____

PHI AUTHORIZATION FORM

TO ACCESS PROTECTED HEALTH INFORMATION (PHI)

The plan sponsor hereby authorizes the following employees and other authorized individuals, such as plan sponsor's broker, to access PHI with respect to the plan. Please provide name, title or other identifiers below:

Name	Title	Phone number	Email address	Access to web? (yes/no)

Broker, consultant or other authorized third party:

Name	Title	Phone number	Email address	Access to web? (yes/no)
Mark Gastineau	Protect Plans Program Manager	469-269-2226	mgastineau@insurgencybenefits.com	Yes
Scott Geske	Protect Plans Program Manager	469-269-2226	scott_geske@hotmail.com	Yes

By signing below, I acknowledge that I have the authority to grant such access on behalf of the plan. I further acknowledge that the plan has an appropriate and fully executed business associate agreement in place with the authorized recipient, if not an employee. Information being shared with the authorized recipient is the minimum necessary in accordance with HIPAA.

This authorization form replaces all prior PHI authorization forms and includes all persons who may access PHI on behalf of the plan sponsor.

Signature of the plan sponsor: _____

Printed name and title: _____

Company name: _____ Date: _____