MERITAIN HEALTH
An Aetna Company

SCRIP WORLD

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, consultant or other authorized third party, to access PHI with respect to the plan. Please provide name, title or other identifiers below:

Employee, Broker, Consultant or other authorized third party	Add Remove Change	Title	Phone number	Email address	Access to web? (yes/no)
Mark Gastineau	☑ Add ☐ Remove ☐ Change	Protect Plans Program Manager	469-269-2226	mgastineau@insurgencybenefits.com	◉ Yes ○ No
Scott Geske	☑ Add ☐ Remove ☐ Change	Protect Plans Program Manager	469-269-2226	scott_geske@hotmail.com	◉ Yes ○ No
	☐ Add ☐ Remove ☐ Change				○ Yes ○ No
	☐ Add ☐ Remove ☐ Change				○ Yes ○ No
	☐ Add ☐ Remove ☐ Change				○ Yes ○ No
	☐ Add ☐ Remove ☐ Change				○ Yes ○ No
	☐ Add ☐ Remove ☐ Change				○ Yes ○ No
	☐ Add ☐ Remove ☐ Change				○ Yes ○ No

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.

Please select one:

☐ This authorization form includes all persons who may access PHI on behalf of the plan sponsor and supersedes any authorizations previously executed.

☐ This authorization form includes a change as to who may access PHI on behalf of the plan sponsor and does not replace all prior PHI authorization forms.

Signature of the plan sponsor: _____

Printed name and title: _____

Company name: _____ Date: _____