9777 Las Vegas Blvd South • Las Vegas, NV 89183 • (702) 797-8940

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

This document authorizes the release of Protected Health Information pursuant to 45 CFR Parts 160 and 164.

1. The undersigned authorizes South Point Benefits to release the following information:

   _____

2. The information may be disclosed by employees or business associates of South Point Benefits.

3. The information may be disclosed to:_____

4. The disclosure may be made for the following purpose(s):

   _____

5. This authorization will expire on_____
   (DATE)

6. I acknowledge: (a) that I have the right to revoke the authorization at any time; and (b) that I understand that once the information is disclosed, it may no longer be protected by federal privacy law.

   (You may revoke this authorization only in writing, sent by certified mail to South Point Benefits at the address above. The revocation will be effective only upon receipt, except (1) to the extent South Point Benefits has acted in reliance on the authorization; or (2) the authorization was obtained as a condition of obtaining insurance coverage and the insurer wishes to use the Protected Health Information to lawfully contest a claim.)

7. I understand that if Protected Health Information about me is disclosed to a person or organization that is not required to comply with federal regulations, the information may be redisclosed and no longer protected by the federal privacy regulations.

Date: _____

Signed By: _____

Print Name:_____

If person signing is other than Member, state authority under which signature is made:

_____