



# Authorization For Release of Information

Please PRINT all information except signature and mail or fax to the address provided below.

I, \_\_\_\_\_, SS#, Employee or FBMC ID# \_\_\_\_\_, hereby authorize Fringe Benefits Management Company to release oral or written benefit information or records about me to the following:

Name	Street Address, City, State

I authorize the release of any/all personal or benefit information maintained by Fringe Benefits Management Company in its capacity as benefit administrator of my plan(s) except as provided below.

Indicate here exceptions or exclusions, if any, to information released.

This authorization for use/disclosure is for the following purpose.

This authorization will remain effective through the end of the current plan year. However, I understand that I have the right to revoke this authorization, in writing, at any time, and that the revocation will be effective except to the extent that Fringe Benefits Management Company has already taken action in reliance on my authorization. My written statement that I want to revoke my authorization should be delivered to:

Fringe Benefits Management Company  
 ATTN. FBMC Privacy Officer  
 3101 Sessions Road  
 Tallahassee, FL 32303  
 Fax Number: 850-425-6220

Signature of Individual/Guardian/Personal Representative	Date Signed	Print Name
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If this authorization has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here:

<b>For Office Use Only</b>
Reference Date: ____ / ____ / ____
Initials: _____