

**Advanced Benefit Planning (ABP)  
MEDICAL RELEASE FORM**

I authorize Advanced Benefit Planning, Inc. to obtain medical information relating to my medical, dental or vision condition (list condition) \_\_\_\_\_ for date(s) of service \_\_\_\_\_.

Employee Name: \_\_\_\_\_

Employee SSN: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Provider Name: \_\_\_\_\_  
(Physician, Hospital, Lab, etc.)

Provider Address: \_\_\_\_\_  
(City, State, Zip Code)

Provider Phone No. (Including Area Code) \_ (\_\_\_\_) \_\_\_\_\_

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

*CONFIDENTIALITY NOTICE:  
Information obtained from medical providers will not be given to Wright State University.*

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