HIPAA AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Submitting this authorization form is optional. You do not need to send it unless you want someone else to have access to your Protected Health Information (PHI) such as your spouse, a family member or friend. This means that in order for us to disclose information about you that is not for the purposes of treatment, payment or health care operations, you must first authorize an individual or organization to receive your PHI. This is your choice. Submitting or not submitting this authorization form will not affect your coverage.

ENROLLING INDIVIDUALS INFORMATION

Individual Name _____

Social Security # _____

Date of Birth _____

I authorize **Flexible Benefit Administrators, Inc.** to use or disclose my individual health information (PHI):

This information may be disclosed **TO** and used by the following individual or organization:

Individual's Name: _____
(i.e. Spouse, Family Member, Friend)

Organization's Name: _____

Address: _____

City, State, Zip: _____, _____, _____

For the purpose of: _____

The type of information to be used or disclosed is as follows:

- ☐ Billing Records
- ☐ Plan Options
- ☐ Eligible Dependents (dependent names)_____
- ☐ Update Personal Information (i.e. mailing address)
- ☐ Entire Record from (date) _____ to (date) _____
- ☐ Other _____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Flexible Benefit Administrators, Inc. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will commence on the date indicated below and will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in three months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to obtain coverage. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information, I can contact this facility's privacy officer.

_____ _____

Signature of Individual or Legal Representative Date

_____ _____

If Signed by Legal Rep., Relationship to Individual Witness

. . . . . .

For those individuals physically unable to sign this authorization:

I, _____, am physically unable to sign this authorization. The two (2) individuals whose signatures appear below have witnessed my verbal consent to the above authorization and my verbal state of my understanding of this authorization.

Name: _____ Signature: _____

Name: _____ Signature: _____

Mail This Form To:	**Fax This Form To:**
Flexible Benefit Administrators, Inc. P.O. Box 2070, Virginia Beach, VA, 23450	Flexible Benefit Administrators, Inc. Fax Number: 757-431-1155