

Authorization for Use or Disclosure of Health Information

As a participant in a Health Flexible Spending Account, Health Reimbursement Arrangement (HRA), or Medical Expense Reimbursement Plan (MERP), certain data relating to your participation is considered to be Protected Health Information (PHI) pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This form provides authorization for the disclosure and/or use of individually identifiable health information, as shown below, consistent with State and Federal law concerning HIPAA Privacy and State Privacy Laws. This authorization will remain in effect until the end of the plan year plus any claim roll out period unless amended or terminated by you.

Employee/Participant Name: _____ **Social Security Number:** ____ - ____ - ____

I authorize release of information regarding my participation in one of the above accounts to the following individuals. The information that may be released shall be limited to those indicated. Information that may be released are dates of service, total charges, provider of service, account balance remaining, denial reason, and claim status. Diagnosis of participant or eligible dependents will not be disclosed except as required by law. Please indicate any information you do not want disclosed.

Family Members: (Please List) Name	Relationship	Last 4 of Social Sec. No. (To Identify Eligibility)	Do Not Disclose The Following:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Employer/Other Representative Name	Title	
_____	_____	_____
_____	_____	_____

Expiration of Authorization

This authorization will remain in effect until:

End of current Plan Year including any claims incurred during the Plan Year

or

The Claim dated _____ totaling \$ _____

or

Termination Date: _____

Signature

I hereby authorize the use and/or disclosure of Protected Health Information as noted above to those individuals identified. I further understand the following:

- I may revoke this authorization at any time. It must be in writing, signed by me and forwarded to the address below and will be effective upon receipt.
- I can refuse to sign this authorization; however, the individuals designated above will not have authorization for information without it.
- I have the right to receive a copy of this authorization.
- I have the right to inspect information that has been disclosed.
- Information will only be disclosed to those identified above.
- Once information is disclosed, it may no longer be protected under HIPAA; however, California and several other states enacted privacy laws prohibiting subsequent disclosure of health information.

Employee/Participant Printed Name: _____ **Signature:** _____ **Date:** _____

HIPAA PRIVACY STATEMENT

The purpose of this notice is to advise you of our privacy policy in order to explain how we collect nonpublic personal information (including protected health information), the type of information that we may collect, and what information we may disclose to other companies or organizations not affiliated with **your employer**. In the event that this privacy policy is amended in the future, you will receive notification of the changes. Also, we will provide to you a copy of this policy at least once each year.

ACQUISITION OF PERSONAL INFORMATION

We collect nonpublic personal information about the individual participants of group plans, which is provided to us by you, the employer/plan sponsor and health care providers in order to provide benefits under your *FlexChoice125* Cafeteria Plan, Medical Expense Reimbursement Plan (MERP), or Health Reimbursement Arrangement (HRA).

Categories of Information We Disclose

We **do not disclose** any nonpublic personal information about our clients, their employees or former clients and employees to outside parties, except as required by law or specifically requested by you.

Parties to Whom We Disclose Information

We disclose nonpublic personal information only to employer plan sponsors (medical information is only provided to plan sponsors at your request only), individual employee participants, and where required by law - such as under a subpoena or governmental audit. If you request that we disclose medical information about you, you may revoke that permission, in writing, at any time.

Confidentiality and Security of Nonpublic Personal Information

We restrict access to nonpublic personal information to those individuals who need to know that information in order to provide services or products for the plan. We maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard nonpublic personal information.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with Pacific Benefit Consultants, Inc., your Human Resources representative at your employer or the Secretary of the Department of Health and Human Services.