



**AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL INFORMATION  
FOR MY FSAFEDS DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT**

I hereby authorize the use or disclosure of personal information pertaining to my FSAFEDS Dependent Flexible Spending Account (FSA) as described below.

**I understand that any information I authorize another person or entity to receive may be re-disclosed and no longer protected by Federal privacy regulations.**

<b>Date:</b>	<b>SSN/UserID:</b>
<b>Participant's Name:</b>	<b>Telephone:</b>
<b>Address 1:</b>	<b>City, State:</b>
<b>Address 2:</b>	<b>Zip Code:</b>

1. All personal information pertaining to my FSAFEDS Dependent Care FSA may be disclosed except for:

\_\_\_\_\_  
\_\_\_\_\_

2. FSAFEDS is authorized to disclose personal information pertaining to my FSAFEDS Dependent Care FSA to the following person(s) or entity:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to receive payment, or eligibility for benefits unless allowed by law.

4. I understand that I may inspect or copy the information to be disclosed.

5. I understand that I may revoke this authorization at any time by notifying FSAFEDS, in writing, except to the extent that:

- a) FSAFEDS has taken action in reliance on this authorization; or
- b) If this authorization is obtained as a condition for obtaining insurance coverage. Other law provides the insurer with the right to contest a claim under the policy.

6. Expiration date of this Authorization:

\_\_\_ Until termination from plan, **or**  
\_\_\_ As of date for specific event \_\_\_/\_\_\_/\_\_\_

\_\_\_\_\_  
Signature of FSAFEDS participant

\_\_\_/\_\_\_/\_\_\_  
Date

\_\_\_\_\_  
Printed name of personal representative

\_\_\_\_\_  
Relationship to FSAFEDS participant or representative's authority to act

**The Federal FSA Program**

FSAFEDS Program • PO Box 36880 • Louisville, KY 40233 • [www.FSAFEDS.com](http://www.FSAFEDS.com)

## **INSTRUCTIONS FOR COMPLETING – AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL INFORMATION**

Please complete this form, using the following simple instructions. If you have questions, please do not hesitate to call our toll-free customer service number at 1-877-FSAFEDS (372-3337), Monday through Friday, 9:00 a.m. until 9:00 p.m., Eastern Time.

Item #1 – Please include a description of the information that you are **not authorizing** FSAFEDS to use or disclose (for example, claim detail, specific dates of service, type of service rendered).

Item #2 – Please include the name(s) of the individuals with whom we may discuss your account. Please include the full name(s).

Item #3 – Please provide us with an expiration date for this authorization. You may state that the authorization remains in force until you are no longer covered under the plan, or following a specific event (such as following a one-time response to an attorney).

**PLEASE NOTE:** This authorization is not valid unless signed and dated. If you are signing as a personal representative (for example, as Power of Attorney), you must include your authority to act for the individual.

Please mail/fax the form to:

**FSAFEDS Program  
P.O. Box 36880  
Louisville, KY 40233  
Fax: 1-866-643-2245**

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