AUTHORIZATION FOR USE AND DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information 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.

Date:	**UserID:**
Name:	**Telephone:**
Address 1:	**City, State:**
Address 2:	**Zip Code:**

1. All individually identifiable health information may be disclosed except for:

   _____

   _____

2. FSAFEDS is authorized to disclose my individually identifiable health information 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 obtain treatment, 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 employee, spouse, dependent — Date

_____ _____

Printed name of personal representative — Relationship to employee, spouse, dependent or representative's authority to act

INSTRUCTIONS FOR COMPLETING – AUTHORIZATION FOR USE AND DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

"Individually identifiable health information" is information about you that is created or received by a health care provider, health plan, employer, or health care clearinghouse, and that relates to your past, present, or future medical care, including payments for health care.

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), TTY: 1-800-952-0450, 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 FSAFEDS 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