WageWorks®

# *Authorization for Release of Protected Health Information (HIPAA)*

**Note:** Any covered participant over the age of 18 requires a separate Authorization Form to be completed.

I hereby authorize the use and disclosure of my individually identifiable health information as described below.

I understand that signing this Authorization is voluntary and that if I refuse to sign this form it will not prevent receipt of health care or eligibility for benefits under a health plan.

I understand that I am entitled to receive a copy of this form upon signing it.

I understand that if the organization or individual authorized to receive the information is not a health plan or healthcare provider; the released information may no longer be protected by federal privacy regulations.

I understand that I have a right to revoke this Authorization, but that I must send a written revocation to the address below. I also understand that the revocation applies to uses and disclosures made after the revocation is made.

**■ SECTION A - INDIVIDUAL AUTHORIZATION USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)**

Name (Plan Participant) _____

Address_____

Phone Number (_____) _____ Last 4 digits of your Social Security # _____

**■ SECTION B - THE USE AND/OR DISCLOSURE BEING AUTHORIZED**

**PHI to be used and/or disclosed:** (Specifically describe the PHI to be used and/or disclosed):

_____

_____

**Entities or Persons Authorized to Use or Disclose your PHI:** {Name or specifically describe the persons and/or organizations (or the classes of persons and/or organizations), including us, who are authorized to make use of and/or to disclose the PHI described above}: _____

**Entities or Persons Authorized to Receive your PHI:** {Name or specifically identify the persons and/or organizations (or the classes of persons and/or organizations), including us, who are authorized to receive, and subsequently use and/or disclose the PHI described above}: _____

**Purpose of this Authorization**

❑ At request of individual.

❑ For the following purposes:

_____

_____

❑ **Check if this authorization is for psychotherapy notes.**

***If this authorization is for psychotherapy notes, you must NOT use it as an authorization for any other type of PHI.***

**No Conditions:** This authorization is voluntary. We will not condition your enrollment in a health plan, eligibility for benefits or payment of claims on giving this authorization. **Effect of Granting this Authorization:** The PHI used or disclosed may be subject to re-disclosure by the recipient, in which case it may no longer be protected under the HIPAA Privacy Rule.

**■ SECTION C - EXPIRATION AND REVOCATION**

**Expiration:** This authorization will expire (complete one):

❑ On _____/_____/_____

❑ On occurrence of the following event (which must relate to the individual or to the purpose of the use and/or disclosure being authorized):_____

**Right to Revoke:** I understand that I may revoke this authorization at any time by giving written notice of my revocation to WageWorks. I understand that revocation of this authorization will not affect any action you took in reliance on this authorization before you received my written notice of revocation.

**■ INDIVIDUAL'S SIGNATURE**

I, _____, have had full opportunity to read and consider the contents of this authorization, and I understand that, by signing this form, I am confirming my authorization of the use and/or disclosure of my protected health information, as described in this form.

Print Name _____

Signature: _____ Date: _____

If this revocation is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name:_____

Signature: _____ Date: _____

Relationship to Individual: _____

*** * YOU MAY REFUSE TO SIGN THIS FORM * ***

**AFTER YOU HAVE SIGNED THE AUTHORIZATION, KEEP A COPY FOR YOUR RECORDS**

**Submit this completed form to: WageWorks, Inc.**
**Fax: 877-782-8889 or E-mail to: Flexhelp@takecareWageWorks.com**
**Phone: 800-950-0105**