take care®
by WageWorks

HIPAA AUTHORIZATION

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 healthcare 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 AUTHORIZING USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Participant Name:

Mailing address:

City, State, Zip: | Phone:

Social Security # or Your Participant ID # *as assigned by your program sponsor:*

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.*

☐ 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.

Entities or Persons Authorized to Use or Disclose: *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: *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:

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. 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.

SECTION D - 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:

AFTER YOU HAVE SIGNED THE AUTHORIZATION, KEEP A COPY FOR YOUR RECORDS. **YOU MAY REFUSE TO SIGN THIS FORM**

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

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