

## AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

For the Benefit Programs:	<b><u>Medical Flex Spending Account or Health Reimbursement Account</u></b>	
Sponsored by <b>The Employer:</b>		
Name of Participant:		
Social Security Number:		
Phone Number:		
Mailing Address:		
Information to be Released (Please specify):		
Release Information To:		
Reason For This Release of Information: (check one)		<b>For assistance in a benefit claim situation</b>
		<b>Other – please explain below</b>
<b>Please read all statements carefully</b>		
I understand that my medical records and information are protected under HIPAA (Health Insurance Portability and Accountability Act of 1996).		
I understand that under Federal Protected Health Information regulations, I have a right to review my record and request amendments where appropriate.		
I understand that my health information may be subject to re-disclosure and not protected by state or federal statutes (upon appropriate and authorized court orders).		
I understand that the specific information to be disclosed in my medical records may include information regarding drug or alcohol use, counseling referrals and/or a history of testing or treatment of acquired immune deficiency syndrome (AIDS) or related conditions.		
I understand that FlexToday, Inc. acts in the capacity of Contract Administrator and HIPAA Business Associate to assist The Employer, as shown above, in the administration of benefit programs offered by the Employer. In all cases and in all events, The Employer is and shall be deemed the Plan Administrator.		
I understand that I may revoke this authorization at any time by notifying FlexToday in writing except that revocation will not cancel or invalidate any action taken by FlexToday upon the original Authorization for Release of PHI.		
I understand that this Authorization of Release will expire in 30 days from the date signed.		
This form will not be accepted unless it is signed and dated in front of an <b>authorized representative</b> of the Employer shown above OR it is notarized.		
<b>X</b>		
Signature of Participant	Date Signed	
<b>X</b>		
Witness Signature	Date Signed	

**Please send this form to: FlexToday, Inc.**  
**PO Box 65007**  
**Pinedale, CA 93650-5007**  
**Phone: 800-995-5373**  
**Fax 559-432-6220**