AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

The Benefit Plan:	The group health plan benefit sponsored by the Employer listed below, including the administration of COBRA or the benefits offered under a Medical Flex Spending Account benefit of a Flexible Spending Account Plan or a Health Reimbursement Arrangement.					
Sponsored by The Employer:						
Employee/Participant Name:						
Date of Birth:		**Zip Code:**		**Last 4 # SSN:**		
Street Address:						
City, State Zip:						
Email Address:						
Release Information To: **Name:**						
Address:						
Phone:		**Relationship:**				
Date of Birth:		**Zip Code:**		**Last 4 # SSN:**		
Information to be Released:	✔ **Assistance and information regarding health benefits (Default)**					
	☐ **Other - Describe**					
This form shall be effective until: (Choose one)	☐ **30-DAYS. This Authorization will expire in 30 days from the date signed.**					
	✔ **UNTIL REVOKED. This Authorization shall remain in effect and in full force until revoked in writing by the Employee/Participant. (Default)**					

Please read statement carefully: I hereby request that my account information be released to the individual(s) shown above. 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 to assist The Employer, as shown above, in the administration of certain benefit programs offered by the Employer. In all cases and in all events, The Employer is 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.

EMPLOYEE/PARTICIPANT SIGNATURE:	DATE SIGNED:

To protect your privacy, please return by fax or drop it into the Secure Claims Portal.

Please send this form to

FlexToday, Inc.
PO Box 16099
Fresno, CA 93755

Phone: 800-995-5373
Fax: 888-207-2310