



**Health Care Flexible Spending Account (HCFSA)
Protected Health Information (PHI) Authorization Form
Health Insurance Portability and Accountability Act (HIPAA)**

40 Rector Street, Third Floor, New York, N.Y. 10006
Tel: (212) 306-7760 TTY: (212) 306-7629

Plan Year
2010

Please Read:

We are unable to speak to anyone other than the participant about personal information or claims unless we have an authorization on file. If you would like to authorize a person to receive private information, please fill out this form. In order for the authorization to be valid, you must sign and fill out the form completely. You must list the specific person or organizations you are authorizing in Section II. Also, you must provide a description of the information in Section III. For example, if you would like your spouse/domestic partner to receive information about your medical claims, you must list your spouse/domestic partner in Section II, and write "medical claims information" in Section III. Please return your authorization form to the address above, in care of "HCFSA HIPAA OFFICE."

I. Participant information (please print)

LAST NAME:		FIRST NAME:		SOCIAL SECURITY #:	
ADDRESS:		CITY:		STATE:	ZIP:
DATE OF BIRTH:	HOME TELEPHONE: ()	WORK TELEPHONE: ()			
AGENCY NAME:					

II. Specific person/organization (or class of persons) authorized to receive and use PHI:

NAME	RELATION TO PARTICIPANT	NAME	RELATION TO PARTICIPANT
1.		2.	
3.		4.	
5.		6.	

III. Specific description of the information: (medical examination reports, Explanation of Benefits, etc)

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IV. Acknowledgement and Right to Revoke:

I understand that I have the right to revoke this authorization at any time by notifying HCFSA in writing at 40 Rector Street, 3rd Floor, New York, NY 10006. I understand that the revocation is only effective after it is received and logged by HCFSA. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation. I understand that after this information is disclosed, federal law might not protect it and the recipient might redisclose it. I understand that I am entitled to receive a copy of this authorization. I understand that this authorization will expire when my employment with the City terminates.

Signature: _____ Date: _____

If a Personal Representative executes this form, that Representative warrants that he or she has authority to sign this form on the basis of: _____