

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

HIPAA AUTHORIZATION

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

Name _____

Address _____

Phone Number (____) _____ Social Security # or your Participant ID # as assigned by WageWorks, formerly Creative Benefits _____

■ **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 to WageWorks, formerly Creative Benefits 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: _____

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

Submit to: WageWorks, Inc., formerly Creative Benefits
PO Box 1928
Vista, Ca 92085-1928

Phone: Toll-Free (888) 295-5656 or (760) 758-4600
Fax: (888) 672-3631
www.creativebenefits.com