

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

| Section A – Individual Authorization Use and/or Disclosure of Protected Health Information (PHI) | | | |
|--|--|--|--|
| Participant Name | | | |
| Mailing address | | | |
| City, State, Zip Code | | Telephone | |
| Social Security # or Your Participant ID # as assigned by WageWorks | | | |
| Section B – The Use and/or Disclosure Being Authorized | | | |
| PHI to be used and/or disclosed: <i>Specifically describe the PHI to be used and/or disclosed.</i> | | | |
| <input type="checkbox"/> Check if this authorization is for psychotherapy notes. <i>If this authorization is for psychotherapy notes, you must NOT use it as an authorization for any other type of PHI.</i> | | | |
| Entities or Persons Authorized to Use or Disclose: <i>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.</i> | | | |
| Entities or Persons Authorized to Receive: <i>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.</i> | | | |
| Purpose of this Authorization | | | |
| <input type="checkbox"/> At request of individual <input type="checkbox"/> 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): | | | |
| <input type="checkbox"/> On ____/____/_____ <input type="checkbox"/> 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, Inc. 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.

Submit to: **WageWorks, Inc.**
Claims Administrator
PO Box 14053
Lexington, KY 40512

Fax: **(866) 672-3703**