

**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)			
<b>Participant Name</b>			
<b>Mailing address</b>			
<b>City, State, Zip Code</b>		<b>Telephone</b>	
<b>Social Security # or Your Participant ID # as assigned by WageWorks</b>			
Section B – The Use and/or Disclosure Being Authorized			
<b>PHI to be used and/or disclosed:</b> <i>Specifically describe the PHI to be used and/or disclosed.</i>			
<input type="checkbox"/> <b>Check if this authorization is for psychotherapy notes.</b> <i>If this authorization is for psychotherapy notes, you must NOT use it as an authorization for any other type of PHI.</i>			
<b>Entities or Persons Authorized to Use or Disclose:</b> <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>			
<b>Entities or Persons Authorized to Receive:</b> <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>			
<b>Purpose of this Authorization</b> <input type="checkbox"/> At request of individual <input type="checkbox"/> For the following purposes:			
<b>No Conditions:</b>		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.	
<b>Effect of Granting this Authorization:</b>		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			
<b>Expiration:</b> 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):			
<b>Right to Revoke:</b> 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**