

# HIPAA Authorization

SUBMIT COMPLETED FORM TO: [customercare@healthsecurehra.com](mailto:customercare@healthsecurehra.com) • HealthSecure HRA Plan, PO Box 80587, Seattle, WA 98108

By completing this Authorization form and returning it to the HealthSecure HRA Plan, I acknowledge and I hereby authorize the HealthSecure HRA Plan to use and/or disclose my Protected Health Information ("PHI") as described below. I also acknowledge and understand the following:

- This authorization is voluntary. No individual has coerced me into signing this authorization, and I am providing this Authorization of my own free will.
- Once this information is received by the authorized person(s) listed in section 2 below, it may then be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws.
- The HealthSecure HRA Plan is not responsible for ensuring that any recipient of my PHI (in accordance with this Authorization) will further use and/or disclose the information for the purposes listed below.
- I have the right to revoke this Authorization at any time by sending a written request to the HealthSecure HRA Plan. The revocation will not affect any actions taken by the HealthSecure HRA Plan prior to receiving my revocation. **For information on how to revoke this Authorization, please contact us at 1-888-364-5027.**
- Unless otherwise revoked, this Authorization will expire upon my death.
- The person listed in section 2 below may not condition treatment, payment, enrollment, or eligibility for benefits on my executing this Authorization.

## 1. PARTICIPANT AND ACCOUNT INFORMATION

Account Number(s)

Last Name

First Name

M.I.

Date of Birth (mm/dd/yyyy)

## 2. HIPAA AUTHORIZATION DETAIL

### A. The following person(s) is authorized to receive, use, and or disclose my PHI:

Authorized Contact

Mailing Address

City

State

Zip

Area Code and Phone Number

Email Address

### B. The following is a description of the PHI the Plan is authorized to disclose to the person(s) listed above:

**Instruction:** In order for this Authorization to be valid, you must specifically and meaningfully describe the PHI to be disclosed. Such detail should include dates and conditions, if applicable. Your description must be specific enough so that the person(s) receiving the Authorization can clearly understand which information this Authorization is intended to cover. You may authorize disclosure of your entire medical record by writing "all health information".

### C. The purpose of this disclosure is:

## 3. REQUIRED AUTHORIZING SIGNATURE

By signing the below, I acknowledge and affirm the statements in this HIPPA Authorization form.

X

Participant Signature

Date (mm/dd/yyyy)

Phone Number Where I Can Be Reached

If this Authorization is signed by a person with authority to act on behalf of the Participant, please complete the following information. **If you are not already listed as an authorized contact on the Participant's account**, you must also attach the appropriate documentation demonstrating your authority to act on behalf of the Participant (e.g., Power of Attorney, Guardianship, etc.).

X

Signature of Authorized Representative

Date (mm/dd/yyyy)

Print Name of Authorized Representative

Phone Number Where I Can Be Reached