WageWorks

HIPAA Authorization

New York State Flex Spending Account

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

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

Participant Name:

Mailing address:

City, State, Zip: | Phone:

NYS Employee ID #:_____ _____

SECTION B - USE AND/OR DISCLOSURE BEING AUTHORIZED

Scope of Information. I authorize WageWorks to use or disclose

☐ All of my PHI, including, but not limited to, account information (e.g., balances, plan details, claims, card transactions and reimbursements)

OR

☐ Only the following PHI: _____

Designated Recipient(s). I authorize WageWorks to use or disclose the PHI described above to the following recipient(s):

Purpose. This HIPAA Authorization is made:

☐ "At request of the individual"

OR

☐ Only for the following purpose: _____

This HIPAA Authorization is voluntary. Your enrollment in a health plan, eligibility for benefits or payment of claims is not conditioned upon the provision of this authorization.
The PHI used or disclosed may be subject to re-disclosure by the recipient(s), in which case it may no longer be protected under the HIPAA Privacy Rule.

SECTION C - EXPIRATION AND REVOCATION

Expiration. This HIPAA Authorization will expire (complete one):

☐ On _____/_____/_____
month day year

OR

☐ 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 HIPAA Authorization at any time by giving written notice of my revocation to WageWorks. I understand that revocation of this HIPAA Authorization will not affect any action WageWorks took in reliance on this authorization before receipt of my written notice of revocation.

SECTION D INDIVIDUAL'S SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this HIPAA Authorization, and I understand that, by signing this form, I confirm my authorization of the use and/or disclosure of my PHI, as set forth 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 14766
Lexington, KY 40512-4766

Fax: (866) 672-3703