Fax Completed Form to: 1-402-978-3728

You may also Mail a Completed Form to: PayFlex Systems USA, Inc., P.O. Box 3039, Omaha, NE 68103-3039

AUTHORIZATION TO RELEASE PERSONAL INFORMATION

PLEASE READ THE FOLLOWING: This form authorizes PayFlex Systems USA, Inc. (PayFlex) to release, at your request, your personal information to another person or organization that you designate.* Personal information may include but is not limited to the following: claim information (including provider name, substantiation and dollar amount), reimbursement information, explanation of benefits (EOB), receipt request letters, premium amounts, insurance carrier name, web access, debit card, bank account information and general plan inquiries. Once information is disclosed pursuant to this authorization, the federal privacy standards (45 C.F.R. Part 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from re-disclosing it. Unless earlier revoked in writing, this authorization expires automatically at the end of the twelve-month period following termination of your coverage. Revoking this authorization will not affect any actions taken prior to the receipt of your written request. This request is voluntary and the plan cannot condition your eligibility for benefits, treatment, enrollment or claim's payment on the signing of this authorization.

**Note: This form is not to be used in order for providers to file billing, claim or Explanation of Benefits (EOB) information or documentation.*

INSTRUCTIONS

1. To authorize the release of personal information, complete sections A, B, C and E of this form and return to PayFlex.
2. To revoke/cancel authorization complete sections A, B and D of this form and return to PayFlex.
3. PayFlex will not process the request if this form is not completed in its entirety, signed and any necessary documentation included.

✓ **Please Print Clearly**

SECTION A - PARTICIPANT INFORMATION: Individual whose information will be released.

RECIPIENT MUST PROVIDE ALL INFORMATION LISTED IN SECTION A WHEN CONTACTING PAYFLEX TO ACCESS PARTICIPANT ACCOUNT

Name (First, MI, Last):	Member Number: OR Social Security Number (Last four digits only):	
		XXX – XX –

Address	City	State	Zip Code

Employer Name (Previous employer if COBRA)	Daytime Phone: (__ __ __) __ __ __ – __ __ __ __

SECTION B - RECIPIENT INFORMATION: Person or organization authorized to receive Participant information.

☐ CHECK BOX AND COMPLETE ADDITIONAL FORM(S) IF THERE IS MORE THAN ONE RECIPIENT YOU WISH TO AUTHORIZE.

Recipient and/or Organization Name:

Address	City	State	Zip Code

Relationship to Participant Select only one	* Legal Representative ☐	Spouse ☐	Dependent ☐	Parent ☐	Friend ☐	Other (specify) ☐

* If the participant is unable to complete this form and you are the participant's Legal Representative then:

1. This form should be completed by you and must be accompanied with legal documentation of your representation, such as a court order Durable Power of Attorney, Guardianship or Conservatorship; **or**
2. For deceased participants, this form should be completed by the participant's Legal Representative (person named as executor or administrator) and must be accompanied by proof that the individual requesting the release is the legal representative of the estate.

Note: Durable Power of Attorney or designation as decision-maker in an Advance Directive, Guardianship or Conservatorship are not valid after the death of the participant.*

SECTION C - INFORMATION TO BE RELEASED TO RECIPIENT: Select only one.

☐ **Grant Full Account Privileges** (equivalent to that of the Participant, allows the Recipient to receive all account information, submit claims and required documentation and make changes to the account such as resetting web login and password, requesting debit cards and changing bank information)

☐ **Grant Limited Account Privileges** (for informational purposes only, will not allow Recipient to make or authorize changes for account)

☐ **Grant Specific Account Privileges** as described:

SECTION D - REVOCATION / CANCELLATION REQUEST: Complete only when requesting revocation/cancellation. Revocation/Cancellation request require Sections A, B and D to be completed. Revoking authorization will not affect any actions taken prior to your written request being received.

I wish to revoke/cancel account privileges for (Recipient Name):

Print Name	Signature	Date

SECTION E - SIGNATURE:

By signing below, I request and authorize the release of my information, which may include protected health information, as described above, until I revoke/cancel or change this request in writing. This authorization expires automatically at the end of the twelve-month period following termination of your coverage unless earlier revoked in writing. I understand this request is voluntary and the plan cannot condition my eligibility for benefits, treatment, enrollment or claim's payment on the signing of this authorization. I also understand that once information is disclosed pursuant to this authorization, the federal privacy standards (45 C.F.R. Part 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from re-disclosing it.

Print Name

Signature	Date	Rev. 4-11

Retain a copy of this completed form for your personal records.