HealthEquity®

www.HealthEquity.com

HIPAA AUTHORIZATION

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:

Employer Name: | Last 4 digits of Social Security #:___ ___ ___ ___ OR Your Participant ID #:_____

SECTION B - USE AND/OR DISCLOSURE BEING AUTHORIZED

Scope of Information. I authorize HealthEquity 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 HealthEquity to use or disclose the PHI described above to the following recipient(s):

_____

_____

_____

P**urpose.** 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 HealthEquity. I understand that revocation of this HIPAA Authorization will not affect any action HealthEquity 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 HIPAA AUTHORIZATION, KEEP A COPY FOR YOUR RECORDS.

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

Fax: 866.672.3703