



Authorization to Release Protected Health Information (PHI)

Participant's Full Name		Employee ID or Social Security Number	
Street Address			
City, State & Zip			

I understand that I am making a voluntary authorization and that I may revoke this authorization at any time by submitting my revocation in writing to ASIFlex. I hereby authorize ASIFlex to use and/or disclose my individually identifiable health information for my health care flexible spending account to the person(s) designated below:

	Designee's Full Name	Designee's Complete Address
1		
2		
3		

I authorize release of my records (please select only one):

- For events occurring between the following dates: _____ until _____;
- OR
- for all past, present and future periods.

This authorization shall be in force and effect (please select only one):

- Until the following date: _____;
- OR
- As long as I have a health care flexible spending account with ASIFlex;
- OR
- Until a specific event: _____

I am requesting that my records be disclosed for the following purposes:

By completing this form, I understand that I am allowing ASIFlex to share information with the person(s) named above. I also understand that I have the right to revoke this authorization provided that I do so in writing, except to the extent that ASIFlex has already used or disclosed the information based on this authorization. I understand that I am not required to sign this form in order to use my health care flexible spending account. I also understand that any information used or disclosed pursuant to this authorization may be redisclosed by the recipient and may no longer be protected by federal or state law.

Signature of participant

Date

Return this signed authorization to:

ASIFlex
P O Box 6044
Columbia, MO 65205-6044