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):

- o For events occurring between the following dates: _____ until _____;

OR

- o for all past, present and future periods.

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

- o Until the following date: _____;

OR

- o As long as I have a health care flexible spending account with ASIFlex;

OR

- o 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
Fax: 877.879.9038