WageWorks
everyone benefits

HIPAA Authorization

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

Section A – Individual Authorization Use and/or Disclosure of Protected Health Information (PHI)			
Participant Name			
Mailing address			
City, State, Zip Code		**Telephone**	
Social Security # or Your Participant ID *# as assigned by WageWorks*			

Section B – The Use and/or Disclosure Being Authorized

PHI to be used and/or disclosed: *Specifically describe the PHI to be used and/or disclosed.*

☐ **Check if this authorization is for psychotherapy notes.**
If this authorization is for psychotherapy notes, you must NOT use it as an authorization for any other type of PHI.

Entities or Persons Authorized to Use or Disclose: *Name or specifically describe the persons and/or organizations (or the classes of persons and/or organizations), including us, who are authorized to make use of and/or to disclose the PHI described above.*

Entities or Persons Authorized to Receive: *Name or specifically identify the persons and/or organizations (or the classes of persons and/or organizations), including us, who are authorized to receive, and subsequently use and/or disclose the PHI described above.*

Purpose of this Authorization
☐ At request of individual
☐ For the following purposes:

No Conditions:	This authorization is voluntary. We will not condition your enrollment in a health plan, eligibility for benefits or payment of claims on giving this authorization.
Effect of Granting this Authorization:	The PHI used or disclosed may be subject to re-disclosure by the recipient, in which case it may no longer be protected under the HIPAA Privacy Rule.

Section C – Expiration and Revocation

Expiration: This authorization will expire (complete one):
☐ On _____/_____/_____
☐ 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 authorization at any time by giving written notice of my revocation to WageWorks, Inc. I understand that revocation of this authorization will not affect any action you took in reliance on this authorization before you received my written notice of revocation.

Section D – Individual's Signature

I, _____, have had full opportunity to read and consider the contents of this authorization, and I understand that, by signing this form, I am confirming my authorization of the use and/or disclosure of my protected health information, as described 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 14053
Lexington, KY 40512

Fax: **(866) 672-3703**