

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: <i>Specifically describe the PHI to be used and/or disclosed.</i>			
<input type="checkbox"/> Check if this authorization is for psychotherapy notes. <i>If this authorization is for psychotherapy notes, you must NOT use it as an authorization for any other type of PHI.</i>			
Entities or Persons Authorized to Use or Disclose: <i>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.</i>			
Entities or Persons Authorized to Receive: <i>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.</i>			
Purpose of this Authorization <input type="checkbox"/> At request of individual <input type="checkbox"/> 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): <input type="checkbox"/> On ____/____/_____ <input type="checkbox"/> 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.**
PO Box 14055
Lexington, KY 40512

Fax: **(877) 220-3249**