Authorization Form

For the use and / or disclosure of Protected Health Information (PHI)

_____ _____

Associate's Name (please print) Date of Birth

_____ _____

Employee ID Telephone Number

I am signing this authorization form because I would like Staples, Inc. ("Staples") to assist me in resolving a medical insurance claim. By signing below, I authorize _____ to release and disclose to Staples information related to the payment of claims under my health care benefit program for medical care and treatment provided to me and/or my dependents.

This authorization expires_____ month(s) / years (s) following the date below.

I understand that, if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected. I understand that I have the right to revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization.

_____

Associate's Signature

_____

Date