



HIPAA AUTHORIZATION FORM

I. Participant Information

First Name:	Last Name:
SSN or Employee ID:	Date of Birth:
Type of Account (FSA, HRA, COBRA, HSA, Retiree):	

II. Authorized Representative Information

<input type="checkbox"/> I authorize HRC Total Solutions to use or disclose my protected health information (PHI). <input type="checkbox"/> This information may be disclosed to and used by the following individual.	
Individual's First and Last Name:	Relationship:
Mailing Address:	
Last Four of SS#:	Comments:
<input type="checkbox"/> Adding Authorization <input type="checkbox"/> Removing Authorization	

III. Signature




I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to HRC Total Solutions. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will commence on the date indicated below and will expire on the following date, event, or condition:

If I fail to specify an expiration date, event, or condition, this authorization will stay in place until I revoke it. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to obtain coverage. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information, I can contact this facility's privacy officer.

Signature:	Date:
Signer ID: <input type="checkbox"/> Self <input type="checkbox"/> Parent of Minor <input type="checkbox"/> Guardian <input type="checkbox"/> Other Authorized Representative (explain):	

PLEASE RETURN THIS FORM TO HRC TOTAL SOLUTIONS CUSTOMER SERVICE

Monday – Friday 8: 30am-5:00pm EST

 (603) 647-1147 Option 1
  (866) 978-7868
  customerservice@hrcts.com