HIPAA Authorization Form

HRC TOTAL SOLUTIONS

How to File

Form can be submitted by Email, Fax, or Mail

To submit by Email send form to: customerservice@hrcts.com

To submit by Fax print form and send to: (866) 978 – 7868

To submit by Mail print form and send to: HRC Total Solutions 111 Charles St. Manchester NH, 03101

Submitting this authorization form is optional. You do not need to send it unless you want someone else to have access to your Protected Health Information (PHI) such as your spouse, a family member or friend. This means that in order for us to disclose information about you that is not for the purposes of treatment, payment or health care operations, you must first authorize an individual or organization to receive your PHI. This is your choice. Submitting or not submitting this authorization form will not affect your coverage.

Participant's Information

Participant's Name

SSN or Employee ID#

Date of Birth

Type of Account *(FSA, HRA, COBRA, Retiree)*

Authorized Representative Information

I authorize HRC Total Solutions to use or disclose my protected health information (PHI)
This information may be disclosed to and used by the following individual or organization

Individual's Name

Organization's Name/Relationship

☐ Add Authorization ☐ Remove Authorization

Individual's Name

Organization's Name/Relationship

☐ Add Authorization ☐ Remove Authorization

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

☐ Self ☐ Parent of Minor ☐ Guardian ☐ Other Authorized Representative (explain):

Signer Identification (check one)

Note: Proof of legal authorization may be required