Authorization for Release of Protected Health Information

I hereby Authorize the use and disclosure of my individually identifiable health information as described below.

I understand that signing this Authorization is voluntary and that if I refuse to sign this form it will not prevent receipt of health care or eligibility for benefits under a health plan.

I understand that I am entitled to receive a copy of this form upon signing it.

I understand that if the organization or individual authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

I understand that I have a right to revoke this Authorization, but that I must send a written revocation to the address below. I also understand that the revocation applies to uses and disclosures made after the revocation is made.

Patient Name:	
ID Number:	
For JFA Reimbursement Plan Participants (FSA, HRA, HSA) Only:	Social Security Number (last 4 digits): Date of Birth (mm/dd/yy):
Person or organization authorized to RELEASE my health information:	Name: Address: City, State Zip: Phone Number:
Person or organization authorized to RECEIVE my health information:	Name: Address: City, State Zip: Phone Number:
Specific description of information is to be disclosed (be specific, include dates): ☐ All of your Health Information ☐ Other ☐ HIV/AIDS related information and/or records ☐ Mental Health information and/or records ☐ Drug/alcohol diagnosis and treatment information	
What is the purpose of the disclosure?	
This authorization will expire on (date or event):	
Signed:	Date (mm/dd/yy):
Patient Name (Print):	Name of Employer:
If signed by a patient representative Representative Name (Print):	Relationship to Patient, including authority for status as representative:

* * * YOU MAY REFUSE TO SIGN THIS FORM * * *

This form does NOT authorize the release of psychotherapy notes.

This form does not constitute legal advice and is provided "as is." This form is based upon current federal law and is subject to change based upon changes in federal law or subsequent interpretive guidance. This form must be modified to reflect state law where the state law is more stringent.

rhk 11/02

30 Corporate Drive . Clifton Park, NY 12065 (518) 373-0069 . Fax (518) 373-0121
42 South Street . Glens Falls, NY 12801 . (518) 792-0042 . Fax (518) 792-0233 . Flex Fax (518) 792-0226

INSURANCE
EMPLOYEE BENEFITS
FINANCIAL SERVICES
JFA
Jaeger & Flynn Associates, Inc.

Instructions for Completing HIPAA Authorization

Patient Name: **1.**	1. Employee name and dependents under age 18 * Spouse and dependents over age 18 will need to complete and sign their own form
ID Number:	
For JFA Reimbursement Plan Participants (FSA, HRA, HSA) Only:	Social Date of Birth (mm/dd/yy):
Person or organization authorized to RELEASE my health information: **2.**	Name: Address: City, State Zip: Phone Number: 2. Indicate who is allowed to release your information: Carrier, Employer, JFA Flex, JFA Associates, etc.
Person or organization authorized to RECEIVE my health information: **3.**	Name: Address: City, State Zip: Phone Number: 3. Indicate who is allowed to receive your information: Carrier, Employer, JFA Flex, JFA Associates, Spouse, etc.
Specific description of information is to be disclosed (be specific, include dates): **4.** ☐ All of your Health Information ☐ Other ☐ HIV/AIDS related information and/or records ☐ Mental Health information and/or records ☐ Drug/alcohol diagnosis and treatment information	4. If you don't want to state a specific reason for the release of information, write ***Any at the request of the individual***
What is the purpose of the disclosure? **5.**	5. ***Claims, Coverage Issues, Reimbursements***
This authorization will expire on (date or event): **6.**	6. Indicate specific time frame or ***until revoked in writing by undersigned***
Signed: **7.**	Date (
Patient Name (Print): 7. The person who is listed on #1 should sign and date here	Name of Employer:
If signed by a patient representative Representative Name (Print):	Relationship to Patient, including authority for status as representative:

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