INNOVATIVE EMPLOYEE BENEFITS, INC.

INSTRUCTIONS FOR COMPLETING HIPAA PRIVACY AUTHORIZATION FORM

If you would like some person other than yourself to have access to your Flexible Spending Account (FSA) and/or Health Reimbursement Arrangement (HRA or Hybrid) medical information, and allow Innovative Employee Benefits, Inc. to release such information to that person, you must authorize the release of the information in writing.

Since a Durable Power of Attorney for Health Care is only effective after you have lost your capacity to make or communicate decisions, that Power of Attorney does not authorize release of medical information to the person named while you remain competent. If you want some person other than yourself to have access to that information now, while you remain competent, you need to complete and sign a HIPAA Privacy Authorization Form, regardless of whether or not you also have a Durable Power of Attorney for Health Care in place.

In **Section 1.** You need to insert the name of the person who is authorized to receive the information. (One name per authorization form.)

In **Section 2.** You are authorizing IEB to release any/all information with regards to your individual benefit plan.

In **Section 3.** You retain the power to **revoke** the authorization at any time.

The form must be **signed** by the plan participant or by the personal representative of the plan participant. If the form is signed by a personal representative, please include documentation that proves the person is an authorized personal representative. We suggest you photocopy the form and retain for your records.

INNOVATIVE EMPLOYEE BENEFITS, INC.
HIPAA PRIVACY AUTHORIZATION RELEASE FORM

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

1. I, _____, am covered under the _____ (Name of Employer) Plan, and hereby authorize **Innovative Employee Benefits, Inc.** to release and/or disclose the Protected Health Information (PHI) described below to:

   _____.
   (Name of Individual)

   My Contact Information is:

   _____ _____.
   (Daytime Telephone Number) (Email Address)

2. Authorization for Release of Information.

   I hereby authorize the release of my complete benefit plan information, including balances on my account, to whom the payments have been made, the dollar amount of payments that have been made, description of my benefit plan, etc.

3. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

4. I understand that my payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

5. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____
Signature of Plan Participant or Personal Representative Date

_____ _____
Print Name of Plan Participant or Personal Representative Relationship to Plan Participant