WageWorks
www.wageworks.com

HIPAA AUTHORIZATION

Note: Any covered participant over the age of 18 requires a separate Authorization Form to be completed.

SECTION A - INDIVIDUAL AUTHORIZING USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Participant Name:	
Mailing address:	
City, State, Zip:	Phone:
Social Security # or Your Participant ID # *as assigned by your program sponsor:*	

SECTION B - THE USE AND/OR DISCLOSURE BEING AUTHORIZED

PHI to be used and/or disclosed. *Specifically describe the PHI to be used and/or disclosed.*

☐ Check if this authorization is for psychotherapy notes.
If this authorization is for psychotherapy notes, you must NOT use it as an authorization for any other type of PHI.

Entities or Persons Authorized to Use or Disclose: *Name or specifically describe the persons and/or organizations (or the classes of persons and/or organizations), including us, who are authorized to make use of and/or to disclose the PHI described above.*

Entities or Persons Authorized to Receive: *Name or specifically identify the persons and/or organizations (or the classes of persons and/or organizations), including us, who are authorized to receive, and subsequently use and/or disclose the PHI described above.*

Purpose of this Authorization.
☐ At request of individual
☐ For the following purposes:

No Conditions:	This authorization is voluntary. We will not condition your enrollment in a health plan, eligibility for benefits or payment of claims on giving this authorization.
Effect of Granting this Authorization:	The PHI used or disclosed may be subject to re-disclosure by the recipient, in which case it may no longer be protected under the HIPAA Privacy Rule.

SECTION C - EXPIRATION AND REVOCATION

Expiration: This authorization will expire (complete one):
☐ On _____/_____/_____
☐ On occurrence of the following event (which must relate to the individual or to the purpose of the use and/or disclosure being authorized):

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation. I understand that revocation of this authorization will not affect any action you took in reliance on this authorization before you received my written notice of revocation.

SECTION D - INDIVIDUAL'S SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this authorization, and I understand that, by signing this form, I am confirming my authorization of the use and/or disclosure of my protected health information, as described in this form.

Print Name:

Signature:	Date:

If this revocation is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name:

Signature:	Date:
Relationship to Individual:	

AFTER YOU HAVE SIGNED THE AUTHORIZATION, KEEP A COPY FOR YOUR RECORDS.

Submit to: **WageWorks, Inc.**
Claims Administrator
PO Box 14053
Lexington, KY 40512

Fax: (866) 672-3703