INDIANA UNIVERSITY

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AUTHORIZATION TO DISCLOSE INFORMATION

Participant Name: _____ SSN (Employee ID): _____

Address: _____

City: _____ State: _____ Zip: _____

Plan/Employer Name: _____

I hereby authorize to disclose the following information to individual(s) I authorize:

☐ **PHI** ☐ **Account Balance & Transaction Information** ☐ **Both**

Name: _____ Relationship: _____

Address to Mail Disclosed PHI: _____

May we release your PHI over the telephone using your SSN (Employee ID) **and** address as verification? ☐ **Yes** ☐ **No**

May we release your PHI via email? If yes, provide recipient email address.

☐ **Yes** ☐ **No** Email: _____

OFFICE USE ONLY	Reviewed by:	Date:

TO BE READ AND SIGNED BY PARTICIPANT

What is PHI?

PHI is a person's protected health information. Generally, it relates to the past, present, or future physical or mental health or condition of a participant; the provision of health care to a participant; the past, present, or future payment for the provision of health care to a participant; and the identity of the participant directly or where there is enough that can be used to identify the participant.

Types of Information Considered PHI

The type of data that may be released about you if you sign this form includes but is not limited to: Names, full address, elements of dates directly related to you, (effective date, termination date, date of death, etc.), medical record numbers, claim substantiation/ information, check issuance/amount/information, account balance information, debit card activation, health plan beneficiary numbers, account numbers, certificate/license numbers, device identifiers and serial numbers, web Universal Resource Locators (URLs), internet protocol (IP) addresses, and biometric identifiers, (including finger and voice prints).

Disclosure of Your PHI

By signing this form, you are authorizing the disclosure of your PHI in connection with the plan listed above with your employer. Your information will be used only in accordance with the provisions of this authorization and any other disclosure laws that we may be required to follow. However, information may be re-disclosed by the recipient whom you've granted authorization and may no longer be protected by federal or state law.

Expiration/Revocation

You understand that this authorization is voluntary and that you have the option to not to sign it. A refusal to sign it will not affect eligibility for benefits or enrollment, payment for coverage of services or the ability to obtain treatment. **You also understand that this authorization will remain in effect until you revoke it, in writing.**

Participant Signature: _____ Date: _____

Witness or Notary Print Name: _____ Signature: _____ Date: _____

Witness must be the Plan Representative

NOTARY USE ONLY

County of Notarization: (Seal)
Date of Execution:
County of Residence:
My commission expires:
State of:

Please return the completed form to:

IU HSA/FSA
P.O. Box 2905
Fargo, ND 58108-2905
Fax: 888-887-9961