Hennepin County
Authorization for Release of Information

The HIPAA law was enacted to ensure your healthcare information remains private. As the employee and holder of the Spending Account, you may want to authorize someone other than yourself to have access to your P&A Group claim and plan information. For example, you may ask your spouse to contact P&A Group and inquire about a claim. By law, our customer service agents cannot speak to your spouse unless you have authorized the disclosure of protected health information in writing.

In order to make the transition of information as seamless as possible, please complete this form and submit it to P&A Group. Please note: this form can be completed electronically by logging into your P&A Account. You also have the option of sending this form to P&A via fax or mail.

Fax: (833) 752-9412 Mail: 17 Court Street, Suite 500 Buffalo, NY 14202

I. INFORMATION ABOUT THE USE OR DISCLOSURE

I hereby authorize the use or disclosure of my individually identifiable information as described below. I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information.

Participant name: SSN Number:

Persons authorized to receive the information:

Relationship to the participant, including authority for status as representative:

❑ I authorize any and all information shared with the above named persons, with the following exception(s):

Unless otherwise revoked, this authorization will expire on the following date: ____/____/____

If I fail to specify a date, this authorization will expire when I cease to be a participant under this plan.

II. IMPORTANT INFORMATION ABOUT YOUR RIGHTS

I have read and understand the following statements about my rights:

- I may revoke this authorization at any time by notifying the providing organization in writing, but the revocation will not have any affect on any actions the entity took before it received the revocation.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive my health care benefits (enrollment, treatment or payment).
- The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity.
- I have the right to seek assurances from the above-named persons/organizations authorized to receive the information that they will not re-disclose the information to any other party without my further authorization.

III. SIGNATURE OF PARTICIPANT

Signature of participant Date / /