Health Care Flexible Spending Account (HCFSA) Program
Health Insurance Portability and Accountability Act (HIPAA) Protected Health Information (PHI) Authorization Form

Bowling Green Station, P.O. Box 707, New York, NY 10274
Tel: (212) 306-7789 nyc.gov/fsa

-- IMPORTANT --
Please submit this form, electronically to:
https://nyc-fsa.leapfile.net

PLEASE READ:

We are unable to speak to anyone other than the participant about personal information or claims unless we have an authorization on file. If you would like to authorize a person to receive private information, please fill out this form. In order for the authorization to be valid, you must sign and fill out the form completely. You must list the specific person(s) or organization(s) you are authorizing in Section II. Also, you must provide a description of the information in Section III. For example, if you would like your spouse/domestic partner to receive information about your medical claims, you must list your spouse/domestic partner in Section II, and write "medical claims information" in Section III. Please return your authorization form to the address above, in care of "HCFSA HIPAA OFFICE", or submit electronically to https://nyc-fsa.leapfile.net

I. *Participant Information*

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NUMBER
			- -

HOME ADDRESS NUMBER AND STREET	APT. #

CITY	STATE	ZIP CODE

DATE OF BIRTH	HOME PHONE NUMBER (AREA CODE)	WORK PHONE NUMBER (AREA CODE)	MOBILE PHONE NUMBER (AREA CODE)
/ /	( ) -	( ) -	( ) -

AGENCY NAME

II. *Specific person/organization (or class of persons) authorized to receive and use PHI:*

	LAST NAME	FIRST NAME	RELATION TO PARTICIPANT
1.			
2.			
3.			
4.			
5.			
6.			

III. *Specific description of the information (medical examination reports, Explanation of Benefits, etc.) and the purpose for which it may be used or disclosed (to assist in resolving a claim, at the participant's request, etc.)*

IV. *Acknowledgement and Right to Revoke:*

I authorize the HCFSA Program to use or disclose my individually identifiable health information as outlined above. I understand that I can refuse to sign this authorization and that I can inspect or copy the health information that is used or disclosed in accordance with this authorization. I understand that I have the right to revoke this authorization at any time by notifying the HCFSA Program in writing at Bowling Green Station, P.O. Box 707, New York, NY 10274 or emailing the progam via the FSA website and selecting Email FSA. I understand that the revocation is only effective after it is received and logged into the HCFSA database. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation. I understand that after this information is disclosed, federal law might not protect it and the recipient might redisclose it. I understand that I am entitled to receive a copy of this authorization. I understand that this authorization will expire when my employment with the City terminates.

SIGNATURE	DATE
	/ /

If a Personal Representative executes this form, that Representative warrants that he or she has authority to sign this form on the basis of: