Fairfax County PUBLIC SCHOOLS
ENGAGE • INSPIRE • THRIVE

Medical, Dental and Health Care Flexible Spending Account (FSA) HIPAA* Plans' Authorization

(for the Use or Disclosure of Protected Health Information)

Please **PRINT**

______________________________ . ______________________________

Plan participant's full name (last, first, middle initial) — **Participant's FCPS e-mail, phone number, or other contact information**

____

Participant's employee identification number

**Health Insurance Portability and Accountability Act*

I authorize the Office of Benefit Services' staff to disclose: (Check one)

☐ All my HIPAA Plans' information

☐ My information only for the checked plans: ☐ Medical ☐ Dental ☐ Health Care FSA

☐ Only the following health information. Please describe. (For example, "only records regarding claims relating to my 3/17/03 back surgery.") ______________________________

to the following individual or organization:

Name	**Relationship to you**	**Phone number (area code)**	
Street Address	**City**	**State**	**ZIP code**

Attach an additional sheet to this form if more than one person may receive this information.

I understand that when the authorized information is disclosed to the individuals or organizations I have listed, the privacy rule **no longer applies** to it and that those receiving my health information may disclose it to others.

This authorization ends: (*Check one*)

☐ On ______________________________ (Insert date)

☐ One year from the date of my signature

☐ When my coverage ends under all HIPAA Plans

☐ Other (*Describe*) ______________________________

I understand that I have the right to revoke this authorization, which I may do by sending a letter (no e-mail) to the FCPS Office of Benefit Services. This letter must be signed, dated, and include the date the revocation is effective. Revocation will not change any actions that the Plan took before the Office of Benefit Services received my revocation letter. (Sign and date below in whichever space is applicable)

______________________________ **OR** ______________________________

Plan participant's signature — **Signature of individual personal representative, or parent if minor**

______________________________ ______________________________

Date (*month, date, year*) — **Date** (*month, date, year*)

If this authorization is signed by the participant's legal representative (other than a parent of an unemancipated minor), a power of attorney or other legal document designating the representative must be attached to this form.