Town of Wilbraham

AUTHORIZATION

FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I authorize the use and/or disclosure of my protected health information (PHI) as described below:

1. My authorization applies to the information described below. Only this information may be used and/or disclosed pursuant to this authorization:

   Information I provide regarding services rendered to me and my dependents for which I request reimbursement as a participant in the Flexible Benefits Plan- Medical Care Expense Account.

2. I authorize the following persons (or class of persons) to make the authorized use and/or disclosure of my protected health information:

   Lynne Frederick, Assistant Treasurer, Thomas Sullivan, Treasurer.

3. I authorize the following persons (or class of persons) to receive my protected health information:

   Lynne Frederick, Assistant Treasurer, Thomas Sullivan, Treasurer

4. I understand that, if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, such information may be re-disclosed and would no longer be protected.

5. Unless otherwise revoked in writing, this authorization expires on June 30 of the current plan year upon my non-renewal in participation in a flexible spending account. It renews automatically if I re-enroll in my flexible spending account for each consecutive year that I enroll.

6. I understand that I have the right to revoke this authorization at any time. My revocation must be in writing (in the form of a letter) and must be sent to: Thomas Sullivan, Treasurer/Collector, and Lynne Frederick, Assistant Treasurer, Town of Wilbraham, 240 Springfield Street, Wilbraham, MA 01095. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and or/disclose my protected health information have acted in reliance upon this authorization.

7. I understand that treatment, payment, enrollment, or eligibility for health plan benefits may not be conditioned upon my signing an authorization.

8. I understand that without this authorization the town cannot view or use the information necessary to process my requests for reimbursements from my Flexible Spending Account.

9. I understand that I may see or copy any information described in this form if I ask for it and that I will get a copy of this form after I sign it.

10. Personal Representative Authority: The undersigned employee has the explicit authority to act on behalf of the following dependents for whom expenses may incur and for which reimbursement may be sought for out-of-pocket medical, dental and vision expenses:

Name of Dependent:	Relationship to Employee:

Signature of Employee **Name (please print)** **Date**