HIPAA Release Form

Mail or Fax completed form to:

Address: Stanley Benefit Services, Inc., Attn Flex Dept
P.O. Box 8249
Greensboro, NC 27419-0249

Fax: 877-432-9247

STANLEY BENEFITS
Actuaries. Consultants. Administrators.

Authorization to Release Protected Health Information (PHI)
Account holder (the employee participant) must complete this form to authorize the release of PHI of account holder to dependents (including spouses)

1. Account Holder Name	2. Account Holder Date of Birth
3. Account Holder Mailing Address:	4. Account Holder email address:
5. Account Holder Daytime Telephone Number: ( )	6. Last Four Digits of Account Holder's Social Security Number:

HIPAA Release (to be completed by Account Holder)

My protected health information is individually identifiable health information, including demographic information collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse, and relates to: (i) my past, present or future physical or mental health condition; (ii) the provision of the health care to me; or (iii) the past, present, or future payment for the provision of health care to me (PHI).

In accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA), I, the undersigned, grant permission to Stanley Benefit Services, Inc. to disclose PHI to the following person or persons:

_____ _____ _____ _____

Purpose of authorization: ☐ At my request ☐ Family member assisting with health care ☐ Other: _____

Any limitations that I impose on Stanley Benefit Services, Inc. with respect to this authorization are declared below:

_____

_____

This release will remain in effect until the closure of the health savings account (HSA), flexible spending account (FSA), or health reimbursement arrangement (HRA). In addition, I may revoke this Release at any time by notifying Stanley Benefit Services, Inc. of the revocation in writing addressed to Stanley Benefit Services Flex Dept and faxed to 877-432-9247 or mailed to P.O. Box 8249, Greensboro, NC 27419-0249. Your revocation will be effective upon receipt and processing by Stanley Benefit Services, Inc.

- I understand that Stanley Benefit Services, Inc. will not condition the provision of health plan benefits on this authorization
- I further understand that if the persons or entities I authorize to receive my PHI are not health plans, covered health care providers or health care clearinghouses subject to HIPAA or other federal health information privacy laws, they may further disclose my PHI and it may no longer be protected by HIPAA or federal health information privacy laws
- I also release and discharge Stanley Benefit Services, Inc. and its business associates from any and all liability, cost and claims of whatever kind and nature arising from the release of this information
- I understand this authorization expires upon my death

Account Holder: Please provide the following information to the person you have authorized so that we may verify the person's identity and authority to receive the account holder's PHI: (1) account holder's name; (2) account holder's date of birth; (3) account holder's address on record; and (4) last four digits of account holder's social security number.

_____ _____

Signature of Account Holder (employee participant) Date