Participant/Dependent Authorization Request Form

You may give Flores & Associates, written authorization to disclose your Protected Health Information (PHI) to anyone you designate and for any purpose. If you wish to authorize a person or entity to receive your PHI, please complete the information below. Completion of this form will not change the way that Flores communicates with participants.

1. Participant Name:	2. Participant Date of Birth:
3. Participant ID Number:	4. Social Security Number/ Employee ID Number:
5. Participant Address:	

At my request, I authorize Flores and their business associates to disclose my PHI to:
(enter name and relationship of person/entity who will receive your PHI)

6. Name:	7. Relationship:

8. **I authorize Flores and their business associates to disclose the following PHI to the listed person or entity.**

- ☐ Enrollment Information
- ☐ Benefit Information
- ☐ Explanation of Benefits (EOB) Information
- ☐ Premium Payment Information
- ☐ Any Information Requested
- ☐ All Claims Information
- ☐ All services from a specific health care provider (list provider's name): _____
- ☐ Other (please list specific PHI): _____

_____

_____

9. **I would like this authorization to expire on:** _____

If no date is provided, this authorization will continue until revoked by you (the participant) in writing.

-I understand that I may revoke this authorization at any time by giving Flores written notice mailed to the address at the bottom of this form. I also understand that revocation will not affect any action Flores and their business associates took in reliance upon this authorization before receiving my written notice of revocation.

-I also understand that Flores will not condition the provision of health plan benefits on this authorization.

If a HIPAA-covered entity is seeking this authorization from me, I have a right to a signed copy. (If one is not automatically provided, please ask for a copy.)

-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 the Health Insurance Portability and Accountability Act (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 Flores and their business associates from any and all liability, cost and claims of whatsoever kind and nature arising from the release of this information.

-I understand this authorization expires upon my death .

Note: Your employer will not receive your Protected Health Information (PHI).

10. **Participant Signature:** _____ 11. **Date:** _____

12. **If signed on line 10 by a personal representative, then Print the Participant Representative full name below:**

_____

If signing for the participant then describe your authority to act for the participant (e.g., power of attorney, administrator, parent of minor child, executor of estate, etc.): _____

RETURN THIS AUTHORIZATION TO: Flores & Associates Post Office Box 31397 Charlotte, NC 28231-1397 Fax (800) 726-9982	**Please provide the following information to the person you have authorized so that we may verify the person's identity and authority to receive your PHI: (1) your name, (2) your participant ID number, (3) your date of birth, (4) your address on record, and (5) the type of PHI you have authorized to be released.**

NOTE: Flores will consider the effective date of this authorization to be the date Flores enters this authorization into its system, typically within two days following receipt.

Instructions for completing the Authorization Request Form

Note: Your employer will not receive your Protected Health Information (PHI).

• Submitting this Authorization Form is OPTIONAL. You do not need to send it unless you want someone else to have access to your Protected Health Information (PHI) such as your spouse, a family participant or friend. This is your choice. Also, you do not need to submit an authorization form in order for Flores to administer your account.

• Only ONE person per form. Only one person may give their authorization per form. Also, only one person may be authorized per form to receive PHI.

• You MUST fill in the following information on the form; otherwise, Flores cannot accept your authorization request.

1. **Participant's Name** must be filled in the "Participant/Dependent Name" blank.

2. **Participant's Date of Birth** must be filled in the "Participant/Dependent Date of Birth" blank.

3. **Your Participant ID Number** must be filled in the "Participant ID Number" blank.

4. **Participant's Social Security Number or Employee ID number** must be filled in the Social Security Number or Employee ID number blank.

5. **Your Entire Address on record** must be filled in the "Participant/Dependent Address on Record" blank.

6. **Name of Person or Entity** that you are Authorizing to receive your PHI must be filled in the blank for "Name" which is immediately below the statement "At my request, I authorize Flores and their business associates to disclose my PHI to..."

7. **Relationship**. The authorized person's or entity's relationship to you must be filled in the blank "Relationship to Participant/Dependent".

8. **The Type of PHI you are authorizing** this person or entity to receive must be checked in the boxes provided, which are underneath the statement "I authorize Flores and their business associates to disclose the following PHI..." If you check the box for "Any information requested," this means that the person you are authorizing may receive any of your PHI that they request.

9. **Authorization Expires Date** should be filled in the blank after the statement "I would like this authorization to expire on:" If no date is given the authorization will continue in effect until revoked by you (the Participant in writing, or upon the death of the participant.

10. **Your Signature.** You must sign your own authorization form unless you are the legal personal representative (see below) or the parent of a minor child who is giving the authorization.

11. **Date.** The date you sign the authorization form must be filled in the blank next to your signature.

12. **Personal Representatives.** A personal representative is a person who has legal authority to make decisions for the participant/dependent. If a personal representative is signing for the participant/dependent, the personal representative must state their authority to sign in the blank spaces below the signature line. If the personal representative is not a parent, then the document(s) giving the personal representative legal authority to sign must be on file with Flores, for Flores to accept the request (if already submitted and valid, you do not need to submit new forms).