Authorization Form

ENPOINTE FLEXIBLE SPENDING PLAN – MEDICAL REIMBURSEMENT ACCOUNT

Health Plan/OHCA Name

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties also described below.

Description of the specific information to be used or disclosed:

_____
_____
_____
_____
_____

Person or entity requesting the information and authorized to make the requested use or disclosure:_____

Recipient of the information:_____

This information is being requested for the following purpose(s):

_____
_____
_____
_____
_____

This authorization shall remain in effect from the date signed below until _____ (expiration date or event)

I understand that:

- I may inspect or copy the protected health information to be used or disclosed
- I may revoke this authorization in writing by contacting your office at the address above, attention Privacy Officer.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA.
- I may refuse to sign this authorization and that you may not retaliate nor discriminate against me because of my refusal to sign.

☐ If this box is checked, I understand that you will receive compensation from a third party for the use or disclosure of my information.

Covered Person:_____

Signature:_____

Relationship:_____

Date:_____