Wespath
BENEFITS | INVESTMENTS

1901 Chestnut Avenue
Glenview, Illinois 60025-1604
wespath.org

Authorization for Disclosure of Health Information Release

Information

This form allows participants in HealthFlex to authorize the use or disclosure of their protected health information (PHI) that is maintained by HealthFlex. Participants must complete this form in its entirety and must describe the information to be disclosed and the purpose for the disclosure.

Individuals whom you authorize to receive your PHI cannot update personal information (e.g., spelling of name, date of birth, marriage date) or make elections for health coverage benefits. A valid Power of Attorney or Guardianship must be on file in order for individuals to update personal information or make elections for health coverage benefits.

Important Information About Your Rights

I understand that:

- This authorization is voluntary, and I may refuse to sign it.
- I may revoke this authorization at any time prior to its expiration date by sending a written revocation notice to Wespath at the address noted on this form. The revocation will not have any effect on any actions that Wespath took before it received the revocation notice.
- Wespath and HealthFlex may not condition treatment, payment, enrollment, or eligibility for benefits on my providing this authorization.
- The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving person or organization and, upon redisclosure, no longer be protected by federal privacy laws. You have the right to seek assurances from the persons or organizations authorized to receive the information that they will not redisclose the information to any other party without your further authorization.

Instructions

Part 1 – Personal Information
Complete your personal information. Use a black pen and print clearly in CAPITAL LETTERS.

Part 2 – Details for the Authorization
Complete each question listed in Part 2.

Part 3 – Authorized Individuals
Provide information about the individual(s) who you will allow to access your account information and benefit details. Then, enter an effective date.

Part 4 – Signature
Read the acknowledgements and, if you agree, sign and date the form. The form must be notarized. Then, return it to Wespath at the address indicated. Keep a copy of the submitted form for your records.

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Participant Authorization for Disclosure of Health Information

This form authorizes Wespath to release your health information to authorized individuals.

Part 1 – Personal Information

Name _____ Social Security # (last 5 digits) ___ ___ ___ ___ ___

Address _____ Primary phone # _____

_____ Birth date _____

E-mail address _____

Part 2 – Information Release

I hereby authorize the use and disclosure of PHI as described below.

Persons/organizations authorized to receive my information:

_____

_____

Specific description of information to be used and disclosed (including relevant date(s) and conditions, if applicable):

_____

_____

Specific purpose of the disclosure ("at the request of the individual" is sufficient if this authorization was initiated by you and you do not, or elect not to, provide a specific purpose):

_____

_____

This authorization will expire _____. [The authorization must have an expiration date. This can be a specific calendar date or a specific time period (e.g., one year from the date of the authorization is signed), or can be determined by reference to an event relating to the individual or to the purpose of the authorization (e.g., upon termination of enrollment in the health plan)].

Part 3 – Authorized Individuals

The following individuals are authorized to receive information regarding HealthFlex:

Name _____ Relationship _____ Birth Date _____

Name _____ Relationship _____ Birth Date _____

Name _____ Relationship _____ Birth Date _____

This authorization shall be effective beginning (date) _____ and shall remain in effect until it is revoked as specified in Part 2.

Note: Spousal access is not revoked automatically upon divorce. You must contact Wespath to revoke the authorization.

Part 4 – Signature

By signing this form, I acknowledge that:

- I have read and understand the instructions.
- The named individual will not have transactional access to my account(s).
- This release will be effective once it is signed, notarized and submitted to Wespath.
- I may revoke this release at any time by notifying Wespath in writing. Please mail or email the revocation to Wespath. If you email the revocation, please include the compliance department email, ComplianceTeam@wespath.org.
- I agree to indemnify, defend and hold harmless Wespath, its officers, directors, employees, agents and related entities from liability in connection with, or arising out of, the provision of such information or data.

Print name _____

Signature of individual or individual's personal represenative

_____

Date _____

If a personal representative signed above, basis of the representative's authority to act for that individual

_____

Signature of notary _____

State of _____ County of _____

Date _____

Notary seal

If you are **NOT** completing this document online, please complete it and return to Wespath by one of the following methods:

- E-mail (scanned copy) to **activeteam@wespath.org** or
- Fax to **1-847-866-2724** or
- Mail to Wespath
  Active Benefits
  1901 Chestnut Avenue, Glenview, IL 60025

Be sure to keep a copy for your records.

This form includes and/or is requesting personally identifiable information (PII) and/or protected health information (PHI). You are encouraged to make elections and beneficiary designations online at **benefitsaccess.org**. When possible, managing your benefits online is the recommended approach to keep your PII and PHI safe and secure.