(HIPAA) Authorization Form

I, ____________________, give permission to Pro-Flex Administrators LLC to disclose the following protected health information to: ___________________________(Name of Agent/Broker)

Information to be disclosed (check all that apply):
__ Debit Card Transactions information (including vendor names)
__ Reimbursement Information
__ Claims information (including providers and services rendered)
__ Other: ____

This authorization expires on _____/_____/______.

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits. You may inspect or copy the protected health information to be used or disclosed under this authorization. For protected health information created as part of a clinical trial, your right to access is suspended until the clinical trial is completed.

Finally, you may revoke this authorization in writing at any time by sending written notification to Pro-Flex Administrators LLC at 8321 Main Street, Williamsville, NY 14221. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

____ ___________________________
Signature of Participant Date

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Printed Name of Participant