HIPAA authorization form

HealthEquity®

Mail or fax completed forms to:

Address: **HealthEquity, Attn: Member Services**
15 W Scenic Pointe Dr, Ste 100, Draper, UT 84020

Fax: 801.727.1005

Authorization to disclose protected health information

Dependents must complete this form to authorize the disclosure of protected health information to the account holder.

Primary account holder information

Last name	First name		M.I.
Street address	City	State	ZIP
Email address (required)	Daytime phone ( )	SSN or HealthEquity ID number	

HIPAA authorization (to be completed by dependent)

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.

In accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA), I, the undersigned, grant permission to HealthEquity, Inc. to disclose protected health information (as defined in HIPAA) 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 HealthEquity with respect to this authorization are declared below:

_____

_____

This authorization will remain in effect for the duration of the state expiration requirement (may vary from 24-48 months) based off of primary account holder's state of residency. In addition, I may revoke this authorization at any time by notifying HealthEquity of the revocation in writing and sending by fax to 801.727.1005, Attn: Member Services.

If at any time you need to alter this authorization form, please contact HealthEquity at 866.346.5800.

Authorization of HIPAA disclosure (to be completed by dependent)

I understand that by granting this authorization, the person who obtains this information may disclose it to other individuals with or without my consent and in so doing, the information would no longer be protected under HIPAA. I understand that my authorizing the use and disclosure of my information is not a condition of enrollment in this health plan, eligibility for benefits or payment of claims.

Dependent's name (please print)	Date
Dependent's signature	Dependent's date of birth (mm/dd/yyyy)

Note: If the person signing above is a personal representative of the named individual, attach copy of document granting authority to the personal representative.