HIPAA Release Form

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

HealthEquity®
Building Health Savings℠

Authorization to Release Protected Health Information

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

Primary Account Holder Information

Last Name	First Name		M.I.
Street Address	City	State	ZIP
E-Mail Address (required)	Daytime Phone ( )	SSN or HealthEquity ID Number (6 or 7 digits)	

HIPAA Release (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 release will remain in effect until the closure of the health savings account (HSA), flexible spending account (FSA), or health reimbursement arrangement (HRA). In addition, I may revoke this Release at any time by notifying HealthEquity of the revocation in writing and faxed to 801.727.1005, Attn: Member Services.

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

Authorization of HIPAA Release (to be completed by dependent)

I understand that by granting this Release, 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.

Date	Dependent's Date of Birth (mm/dd/yyyy)	Date Authorization Effective Until (If no date is provided, authorization is valid until the preset time frame based on your state.)
Dependent's Name (please print)		Dependent's Signature

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