Crosby Benefit Systems
Authorization for Release of Personal Health Information

This document authorizes Crosby Benefit Systems, a division of WageWorks, Inc. (Crosby) to use and disclose Protected Health Information ("PHI") currently maintained by Crosby subject to the specifications listed below. Authorization may be revoked by the employee/dependent authorizing the release at any time (see Section F below). Unless otherwise revoked, this authorization expires one year from the date it is signed.

Section A. Employee Information

Employee Name: _____

Employee Last 4 of SSN or Employee ID: _____

Date of Birth: _____ Employer: _____

Section B. Employee/Dependent for Whom Information will be Released

This document authorizes the use and/or disclosure of confidential protected health information about the following employee or dependent (spouse, adult or minor dependent, or domestic partner).

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Daytime Phone number: _____

Section C. Directions for Release

This authorization applies in accordance with my directions as checked below. I authorize the Crosby to release and/or use protected health information pertaining to the employee/dependent listed in Section B. I understand that the information to be disclosed and/or used may include enrollment information, eligibility information, premium (payment) information.

CHECK ALL THAT APPLY IN SECTION C.1 and C.2:

C.1 I authorize the disclosure and/or use of the following information:

- ☐ (a) my enrollment, eligibility and premium payment records
- ☐ (b) Other (describe information in detail): _____

C.2 I authorize the disclosure and/or use for the following reason(s):

- ☐ (a) for review and questions of payments
- ☐ (b) for review and questions of my elections
- ☐ (c) Other (describe information in detail): _____

Section D. Person or Entity to Whom Disclosure Will be Made

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Daytime Phone number: _____

Incomplete authorizations will not be processed.

Section E. Authorization and Signature

I authorize the release of my confidential protected health information, as described in my directions in Section C and Section D. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is covered by Florida law which prohibits redisclosure or other laws that limit the use and/or disclosure of my confidential protected health information. Redisclosure by the recipient may occur without my knowledge or consent and the privacy of my personal health information may no longer be protected. My treatment, payment, enrollment and eligibility are not conditioned on signing this authorization but the information authorized may be necessary for claim review and appeal purposes. I, _____, have read the contents of this Authorization, and I confirm that the contents are consistent with my directions. I understand that by signing this form, I am authorizing the use and/or disclosure of my confidential protected health information.

_____ _____

Signature Date

Section F. Right to Revoke

You may revoke this authorization at any time. (Please allow five business days from the date Crosby receives the revocation for Crosby to register the information.) To revoke this authorization, please sign and date below and return the entire completed form to Crosby at the address below. If you have any questions, please contact the Crosby at 800-462-2235.

I hereby revoke my authorization for the release of health information as listed on this form above. I understand that this revocation shall not apply to any action already taken by Crosby Benefit Systems in reliance on the above authorization.

_____ _____

Signature Date

Section G. Legal Representative

Please attach a copy of your power of attorney or a certified copy of your Court Order of your representative capacity. If you are signing on behalf of a minor child, your signature below constitutes your certification that you are the natural guardian of the minor child.

If a Legal Representative (Guardian, Conservator, or Authorized Representative) on behalf of the individual signs this authorization, complete the following:

Legal Representative's Name (PRINTED):_____

Legal Representative's Signature: _____

Date: _____ Daytime Phone Number: _____

If this authorization is being requested/signed by the Legal Representative, you must furnish a copy of the Power of Attorney or other relevant documents designating you as the representative of the individual.

Participant Reminder:

Upon expiration of this authorization, it is the responsibility of the participant to re-authorize the individual. Incomplete Forms will not be processed.

Complete, sign and return this form to:

Crosby Benefit Systems

PO Box 223886, Dallas TX 75222-3886

or fax to 617-928-0001