Navia Benefit Solutions Authorization Form

I hereby authorize the use or disclosure of protected health information as described below. I understand that I may revoke this authorization at any time by submitting my revocation in writing to Flex-Plan Services.

Participant Name: _____

Participant Employer: _____

Information that may be disclosed includes:

> Any and all information related to my benefits administered by Flex-Plan Services. This may include the health flexible spending arrangement (FSA), a health reimbursement arrangement (HRA), the day care FSA, a health savings account, a wellness benefit, COBRA benefits, and transportation benefits (although transportation benefits are not subject to the same laws). I understand that this authorization grants me access to information and do **not** permit me to submit claims (unless legally permitted to do so), make changes to benefits or personal information, and request debit cards).
>
> or
>
> Any and all information related to my benefits at _____ (provider name i.e. a vision provider, hospital or clinic.).

Flex-Plan as a class of persons may use or disclose the information as indicated above. Or the provider may use or disclose the information as indicted above.

Flex-Plan as a class of persons **may use or disclose information to** _____ (spouse's name, family members' name, friend's name, interpreter, or other named individual).

The purpose of the disclosure is to assist in the administration of the benefits. If some other purpose exists please describe that purpose here_____.

This authorization **shall expire** on _____(insert date).

<u>Important Information Regarding Your Rights</u>

I have read and understood the following statements about my rights:

I may revoke this authorization at any time prior to its expiration date by notifying Flex-Plan in writing, but the revocation will not have any effect on any actions that Flex-Plan took before it received the revocation.

I am not required to sign this authorization as a condition to receiving treatment or payment for health care; enrolling in a health plan; or establishing eligibility for benefits.

The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity or person. I have the right to seek assurances from the above-named persons/organizations authorized to receive the information that they will not re-disclose the information to any other party without my further authorization.

I have a right to receive a signed copy of this signed authorization.

Signature of Participant: _____

Date: _____

Signature of Participants Representative (if applicable): _____

Date: _____

For Participant's Representative please provide a **description of authority** to act on behalf of the participant.

_____

_____