

## AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION: FLEXIBLE BENEFIT PLAN

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I, \_\_\_\_\_, hereby authorize the use or disclosure of my health information as described in this authorization.

- 1) *Specific Person/Organization (or class of persons) authorizes to provide the information:*  
**Igoe Administrative Services**
- 2) *Specific Person/Organization (or class of persons) authorized to receive and use this information:* \_\_\_\_\_
- 3) *Specific and meaningful description of the information. A separate release will be required for each transaction (i.e. copies of medical care receipts/documentation and subsequent claims for reimbursement of medical are expenses):*

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- 4) *Purpose of this request (If you do not wish to state a purpose, please state: "At the request of the Person/Organization listed above"):*

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- 5) I understand that after this information is disclosed, federal law might not protect it and the recipient might re-disclose it.
- 6) I understand that my initial and continued employment and position are subject to my agreement to this authorization, and any additional authorization requested by my Employer or the Contract Plan Administrator.
- 7) I understand that I am entitled to receive a copy of this authorization.

Name of Employee: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Signature of Employee: \_\_\_\_\_ Date: \_\_\_\_\_

### *Personal Representatives Section:*

If a Personal Representative executes this form, the Representative warrants that he or she has authority to sign this form on the basis of:

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Personal Representative's Name: \_\_\_\_\_

Please forward this document along with all related paperwork to Igoe Administrative Services, Flexible Benefit Department:

Via email at [flex@goigoe.com](mailto:flex@goigoe.com)

Via fax at 858-673-3666, 858-673-0509, 858-777-5424, 888-357-6307