Clear Form

Protected Health Information (PHI) Release Form

As required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Igoe Administrative Services is committed to protecting your protected health information (PHI). Your PHI cannot be disclosed to a third party without your consent. If you wish to have your PHI shared with another person or organization, please complete all sections of this form.

INSTRUCTIONS

1. **Complete** all sections of this form.
2. **Submit** this form to Igoe Administrative Services:

Submittal Instructions for COBRA Continuants:

- Email to cobra@goigoe.com
- OR Mail to Igoe Administrative Services, P.O. Box 501480, San Diego, CA 92150-1480

Submittal Instructions for Spending Accounts Participants: If you are unable to attach your form or document to an online or mobile app claim or alert, you may use one of these secondary options to send your documentation to us. Please note, that Igoe cannot guarantee the security of any documentation provided to use via the below methods while in transit to our organization:

- Email to flex@goigoe.com
- OR Mail to Igoe Administrative Services, P.O. Box 501480, San Diego, CA 92150-1480

Questions? Use the email addresses listed above or call 1-800-633-8818, option 1(Spending Accounts) or option 2 (COBRA)

Section A: Information About the Designated Recipient

Clear Section A

Name of Designated Recipient/Organization (print)

Address	Employee Number (If Applicable)
Phone Number	Email Address

Section B: Participant Authorization

Clear Section B

Employer Name (Spending Accounts Plan Participants Only) **OR** Former Employer Name (COBRA Continuants Only)

Participant Name	First 5 digits of the SSN

Copies of PHI to be released:

☐ Information Related to COBRA continuation ☐ Medical Care Receipts ☐ Reimbursement Requests
☐ Information Related to Spending AccountsCard purchases Documentation ☐ Additional Reimbursement Request

Please provide specific instructions related to the above information. For example, you may wish to list the date of the reimbursement request or transaction and the dollar amount to ensure that only certain PHI is released. If specific information is not provided, Igoe Administrative Services will supply any information in the above checked categories to the Designated Recipient upon request.

Release effective Date	Release expiration Date

By means of the below signature, I hereby authorize the use or disclosure of my PHI to the Designated Recipient/Organization provided on this form. I understand that a separate release may be required for additional transactions. I understand that after the requested information is disclosed, Igoe Administrative Services cannot ensure its protection under federal law and that the Designated Recipient/ Organization may re-disclose it. I understand that I am entitled to receive a copy of this authorization upon my request.

Signature: Ready To Sign? Click To Print **Date:** _____

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