HIPPA Authorization Form

Authorization to disclose Protected Health Information (PHI) to an individual other than the Medical Flexible Spending Account/HRA holder:

Employee Name: _____

Social Security Number: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

As a Participant in my employer's Medical Flexible Spending Account (FSA) and/or Health Reimbursement Arrangement (HRA) plan, I hereby grant authorization to Group Dynamic, Inc. to disclose my individually-identifiable PHI (relating to current/pending/denied/paid Medical FSA reimbursements) to the following person:

Name: _____

I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to:

Reimbursement Services Manager
Group Dynamic, Inc.
411 U.S. Route One
Falmouth, ME 04105
Fax: 207-781-3841

_____ _____
Employee Signature Date