Group Dynamic Inc.
THIRD PARTY ADMINISTRATION

HIPAA Authorization Form

Authorization for Use and Disclosure of Protected Health Information

Authorization to disclose Protected Health Information (PHI) to an individual other than the FSA, HRA and/or HSA accountholder as required under HIPAA (Health Insurance Portability and Accountability Act).

Accountholder Information

Please complete all information clearly to avoid errors or delays.

Your First & Last Name	
Your Employer Name	
Daytime Phone	
Email Address	

Last 4 Digits of your Social Security or ID Number				

As the accountholder I hereby grant authorization to Group Dynamic, Inc. to disclose my protected health information relating to current, pending, denied, and/or paid claims to the following person:

First & Last Name	

Authorization

This authorization will expire upon my termination of coverage in my employer's FSA, HRA and/or HSA plan. I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to:

Group Dynamic, Inc.
411 US Route One
Falmouth ME 04105
Fax: 207-781-3841
Attn: Privacy Officer

_____ _____

Accountholder Signature Date