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AUTHORIZATION FOR RELEASE OF INFORMATION
Health and Dependent Care Spending Accounts

Must be completed for all authorizations

Participant Name: \_\_\_\_\_ Company: \_\_\_\_\_
Social Security \_\_\_\_\_ Telephone: ( ) - \_\_\_\_\_
Number: \_\_\_\_\_

Please print clearly.

I hereby authorize disclosure of my Health Care Spending Account and/or Dependant Care Spending Account claims reimbursement information as described below. I understand that this authorization is voluntary. I understand that the released information may no longer be protected by federal privacy regulations.

Full Name of Person Authorized to Receive the Information: \_\_\_\_\_

Specific Instructions Pertaining to this Authorization: \_\_\_\_\_

\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

- 1. I understand that this authorization will not expire.
2. I understand that I may revoke this authorization at any time by notifying Benefit Strategies in writing.

Signature of Participant: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Authorized Representative: \_\_\_\_\_

Relationship to Participant: \_\_\_\_\_ Date: \_\_\_\_\_