Western States Carpenters
Health Reimbursement Arrangement
HIPAA Authorization Form

I,_____, give permission to The Harrison Group to disclose the following protected health information to:

_____ _____

Authorized Person(s) Relationship (spouse, parent, child, legal guardian, etc.)

Information to be disclosed (check all that apply):

- ☐ Debit Card Transactions information (including vendor names)
- ☐ Reimbursement Information
- ☐ Claims information (including providers and services rendered)
- ☐ Other:

This authorization expires on _____ (Month/Day/Year)
Note: If date is left blank, authorization will not expire until we receive written notification.

IMPORTANT INFORMATION ABOUT YOUR RIGHTS
I have read and understand the following statements about my rights:

I may revoke this authorization at any time by notifying the providing organization in writing, but the revocation will not have any impact on any actions the entity took before it received the revocation.

I may see and copy the information described on this form if I ask for it.

I am not required to sign this form to receive my health care benefits (enrollment, treatment or payment).

The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity. I have the right to seek assurances from the above-named persons/organizations authorized to receive the information that they will not re-disclose the information to any other party without my further authorization.

_____ _____

Signature of Member Date

_____

Printed name of Member

Please email this completed form to The Harrison Group at
wschra@theharrisongrouponline.com