Flexible Spending Account (FSA)
RELEASE OF INFORMATION AUTHORIZATION

	Fax	Mail
Submit this completed form to TASC via fax or mail (if for an appeal, submit per the appeal instructions):	(608) 663-2762	TASC PO Box 7308 Madison WI 53707-7308

I hereby authorize the use or disclosure of my individually identifiable health information as described below.
I understand that this authorization is voluntary, that I may refuse to sign this authorization and that I may revoke it at any time by submitting my revocation in writing to TASC.

EMPLOYER INFORMATION

Employer Name _____ Employer TASC ID # (if known) _____

PARTICIPANT INFORMATION

First Name:		MI:		Last Name:			
TASC ID # (if known):		Email Address:					
Primary Phone #:		Mobile Phone #:					
Primary Address:	Address Line 1:					Apt:	
	Address Line 2:						
	City:						
	State:		ZIP/Postal Code:			+4	

All fields required to access your account online or via your mobile phone, or to receive personal account notifications. Information is confidential and is not used for marketing purposes.

AUTHORIZATION

Authorized Representative (Persons/Organizations): _____
(Print Name)

Above named representative(s) is authorized to receive information for the purpose of:

☐ Serving as my personal representative for Flexible Spending Account (FSA) appeals.

☐ Other *(describe)*: _____

_____

All of my health information may be disclosed: **Yes** ☐ **No** ☐ *(If no, please describe below)*

Specific information to be used or disclosed: _____

_____

_____

☐ **I understand the specific purpose of the disclosure may be made at the request of the authorized representative (with a current authorization on file).**

☐ **I understand this authorization will expire upon termination of coverage. However, I may revoke authorization at any time by submitting written revocation to TASC.**

Flexible Spending Account (FSA)
RELEASE OF INFORMATION AUTHORIZATION

I have read and understand the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying TASC, in writing, but the revocation will not have any effect on any actions that the authorized representative took before receiving 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 authorized representative. I have the right to seek assurances from the above-named authorized representative that they will not re-disclose the information to any other party without my further authorization.

Signature of Participant: _____ Date: _____
(or Authorized Representative, if previously authorized)

Participant Name (Printed): _____