



## RESTRICTION OF PROTECTED HEALTH INFORMATION (PHI)

### THIS AUTHORIZATION COMPLIES WITH THE HIPAA PRIVACY RULE

I, the undersigned authorize the release of my Protected Health Information (PHI), eligibility, enrollment information, claim status, and claim records to the named person(s) below. I understand by restricting this information, anyone that calls will be required to have the required Password to access any Protected Health Information (PHI) information on my account. **I fully understand that it is my full responsibility to protect my Password from anyone that I do not want to have access to my PHI.** PHI access may be restricted to any and all person(s) covered under my identification number at my discretion.

(Please type or print)

Employee Name:	ID/Social Security Number
Employer:	Group Number
Insured Name:	Relationship:
Access Granted To:	Relationship:
Access Granted To:	Relationship:

<b>ADD</b>	<b>CHANGE</b>	<b>DELETE</b>	
Passwords must be four digit alpha-numeric code e.g. BC12 <b>VOWELS MAY NOT BE USED.</b> Please make your password selection below. A password may be selected for each covered dependent			
ALPHA	ALPHA	NUMERIC	NUMERIC

## OPT OUT RESTRICTION OF PROTECTED HEALTH INFORMATION (PHI)

I choose to OPT out of the Restriction of Protected Health Information (PHI) and allow the release of my Protected Health Information (PHI) to the named person(s) below or to anyone requesting it by signing my selection below. **I understand that I must be at least 18 years old to OPT out of the Restriction of Protected Health Information (PHI).**

I Allow release of PHI to:	Signature:
I Allow release of PHI to:	Signature:
I Allow release of PHI to anyone requesting it	Signature:

Insured Signature:	Date:
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**Mail completed form to FSAI Attn: Eligibility Department**