

**AUTHORIZATION TO RELEASE
PROTECTED HEALTH INFORMATION**

Due to the Health Insurance Portability and Accountability Act (HIPAA), Infinisource™ must safeguard your protected health information (PHI). To best serve you, we require your signature and date below, authorizing Infinisource to disclose your health information to your spouse or dependent regarding your specific claim.

By signing below, I am authorizing Infinisource to disclose my health information to my spouse and/or dependents until I revoke this authority in writing.

Employee Signature

Date

Name of person(s) receiving PHI

Relationship to you

Specific claim information:
If not specific, please
indicate all.

Please fax to Infinisource 937.275.6065



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