HIPAA authorization form

HealthEquity®

Mail or fax completed forms to:

Address: **HealthEquity, Attn: Member Services**
15 W Scenic Pointe Dr, Ste 100, Draper, UT 84020

Fax: 801.727.1005

Authorization to disclose protected health information

Dependents must complete this form to authorize the disclosure of protected health information to the account holder.

Primary account holder information

Last name	First name		M.I.
Street address	City	State	ZIP
Email address (required)	Daytime phone ( )	SSN or HealthEquity ID number (6 or 7 digits)	

HIPAA authorization (to be completed by dependent)

My protected health information is individually identifiable health information, including demographic information collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse, and relates to: (i) my past, present, or future physical or mental health condition; (ii) the provision of the health care to me; or (iii) the past, present or future payment for the provision of health care to me.

In accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA), I, the undersigned, grant permission to HealthEquity, Inc. to disclose protected health information (as defined in HIPAA) to the following person or persons:

_____

Purpose of authorization: ☐ At my request ☐ Family member assisting with health care ☐ Other: _____

Any limitations that I impose on HealthEquity with respect to this authorization are declared below:

_____

_____

This authorization will remain in effect for the duration of the state expiration requirement (may vary from 24-48 months) based off of primary account holder's state of residency. In addition, I may revoke this authorization at any time by notifying HealthEquity of the revocation in writing and sending by fax to 801.727.1005, Attn: Member Services.

If at any time you need to alter this authorization form, please contact HealthEquity at 866.346.5800.

Authorization of HIPAA disclosure (to be completed by dependent)

I understand that by granting this authorization, the person who obtains this information may disclose it to other individuals with or without my consent and in so doing, the information would no longer be protected under HIPAA. I understand that my authorizing the use and disclosure of my information is not a condition of enrollment in this health plan, eligibility for benefits or payment of claims.

Dependent's name (please print)	Date
Dependent's signature	Dependent's date of birth (mm/dd/yyyy)

Note: If the person signing above is a personal representative of the named individual, attach copy of document granting authority to the personal representative.

Nondiscrimination Notice and Access to Communication Services

HealthEquity, Inc.'s ("HealthEquity") primary purpose is to provide non-health services to holders of health savings accounts. In addition to these services, HealthEquity provides services to, and on behalf of, health plans.

HealthEquity, and if applicable, your plan, do not exclude people or treat them unfairly because of sex, age, race, color, national origin, or disability.

Free services are available to help you communicate with us and with your health plan, including providing letters in other languages or in other formats, such as large print. If you need help, please call the toll-free number on your benefits card. For language assistance on your call, simply ask for an interpreter.

If you think you were not treated fairly because of your sex, age, race, color, national origin, or disability, you can send a complaint to:

HealthEquity, Inc.
Attention: Director of regulatory services
15 W. Scenic Pointe Dr.
Draper, UT 84020
Fax: (801) 206-3895
Email: RegulatoryServices@HealthEquity.com

Upon receiving your complaint, we will work with your health plan to address your concerns.
If you need help with your complaint, please call the toll-free number on your member ID card.
You must send the complaint within 60 calendar days of when you found out about the issue.
You can also file a complaint with the United States Department of Health and Human Services online https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

Language Assistance Services

ATTENTION: If you speak English, language assistance services are available to you free of charge. Please call the phone number listed on your benefit debit card.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al número de teléfono que aparece en su tarjeta de débito de beneficios.

注意: 如果您说中文, 将为您免费提供语言协助服务。请致电优惠借记卡上列示的电话号码。

LƯU Ý: Nếu bạn nói Tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ luôn có sẵn cho bạn sử dụng miễn phí. Vui lòng gọi số điện thoại được ghi trên thẻ ghi nợ của bạn.

주의: 한국어를 사용하신다면 , 언어 지원 서비스를 무료로 이용하실 수 있습니다. 혜택 직불 카드에 나열된 전화 번호로 전화를 주십시오.

ATENSYON: Kung nagsasasalita ka ng Tagalog may libreng tulong para sa wika. Mangyaring tawagan ang numero ng teleponong nakalista sa iyong benefit debit card.

ВНИМАНИЕ! Если вы говорите по-русски, помощь переводчика будет предоставлена бесплатно. Позвоните по номеру телефона, указанному на вашей дебетной карте.

تنبيه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية مجانًا. يرجى الاتصال برقم الهاتف المذكور على بطاقة خصم الفائدة الخاص بك.

Atansyon: Si ou pale kreyòl ayisyen, sèvis asistans lang yo disponib pou ou san peye. Tanpri rele nimewo telefòn ki nan kat debi fidelite ou a.

IMPORTANT : si vous parlez français, des services d'assistance linguistique sont à votre disposition sans frais. Appelez le numéro de téléphone indiqué sur votre carte d'assurance maladie.

UWAGA! Zapewniamy bezpłatne usługi językowe dla osób, którzy mówią po polsku. Prosimy dzwonić pod numer telefonu podany na karcie depozytowej.

ATENÇÃO: se falar português, os serviços de assistência linguística estão disponíveis gratuitamente. Contacte o número indicado no seu cartão de débito de benefícios.

ATTENZIONE: Se parli Italiano, il servizio assistenza è gratuito. Puoi chiamare il numero indicato nella garanzia.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。保険給付用デビットカードに記載されている電話番号までお電話にてご連絡ください。

ACHTUNG: Falls Sie Deutsch sprechen, steht Ihnen eine Spreachunterstützung kostenlos zur Verfügung. Bitte rufen Sie die Telefonnummer an, die auf Ihrer Vorteile-Kundenkarte aufgeführt ist.

توجه: اگر به زبان فارسی صحبت میکنید، خدمات و کمکهای زبانی به صورت رایگان به شما ارائه میگردد. لطفاً با شماره تلفن مندرج روی کارت دبیت مزایای خود تماس بگیرید.

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपको मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कृपया अपने बेनेफिट डेबिट कार्ड पर दिए गए फोन नंबर पर कॉल करें।

ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો, તો આપને માટે ભાષા સહાય સેવાઓ વિના મૂલ્યે ઉપલબ્ધ છે. આપના બેનિફીટ ડેબિટ કાડર્ પર લખેલા ફોન નંબર પર કૉલ કરો.

ជូនដំណឹង៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ សេវាជំនួយភាសាគឺអាចរកបានសម្រាប់អ្នកដោយឥតគិតថ្លៃ។ សូមហៅទៅលេខទូរស័ព្ទដែលមានរាយនៅលើប័ណ្ណឥណពន្ធអត្ថប្រយោជន៍របស់អ្នក។

โปรดทราบ: หากท่านพูดภาษาไทย บริการผู้ช่วยด้านภาษาพร้อมให้บริการท่านฟรี โปรดติดต่อหมายเลขโทรศัพท์ตามรายการบนบัตรเดบิตสิทธิประโยชน์ของท่าน

HUBADHU: Yoo afaan oromoo kan dubbattuu ta'e gargaarsi tajaajilawwan afaanii kaffaltii irraa bilisaa ni jira. Maaloo lakkoosa bililaa kaardii liqii faayidaa keetii irra jiruun. bilbili.

ໝາຍເຫດ: ຖ້າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາແມ່ນມີໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ກະລຸນາໂທຫາເບີໂທລະສັບທີ່ໃຫ້ໄວ້ໃນບັດເດບິດເງິນຊ່ວຍເຫຼືອຂອງທ່ານ.