Glynn Griffing & Associates
Professional Service. Personal Care.

P.O. Box 16509
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HIPAA Privacy Policy Consent Form

I understand that I have certain rights to privacy regarding my Protected Health Information (PHI) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent form I authorize you to discuss and disclose my protected health information with the named person to carry out the processing of my health flexible savings account reimbursement requests.

I understand that I may revoke this consent, in writing, at any time; however, any use of disclosure that occurred prior to the date I revoked this consent is not affected.

Participant Name (Print): _____

Name of Person Being Given Consent: _____

Relationship: _____

Date of Birth: _____ Email: _____

Mailing Address (including city, state, and zip):

_____

_____

_____

Expiration Date (Choose one):

☐ Specific Date: _____ ☐ Duration of my coverage

Participant Signature: _____ Date: _____