Release of Information Form

I hereby authorize the use or disclosure of all of my individually identifiable health information for my Health Care Flexible Spending Account with my employer listed below.

I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to Flex Made Easy.

Participant Information:

Name: _____Social Security Number: _____

Participant's Employer: _____

Person(s) authorized to receive information: _____

Important Information About Your Rights

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 Flex Made Easy in writing, but the revocation will not have any effect on any actions Flex Made Easy took before Flex Made Easy received 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 Flexible Spending Account benefits.
- The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving person. I have the right to seek assurances from the above-named person(s) authorized to receive the information that they will not redisclose the information to any other party without my further authorization.

AUTHORIZED SIGNATURE: _____ DATE: _____

****YOU MAY REFUSE TO SIGN THIS FORM****

Please return the completed form via email to info@FlexMadeEasy.com or via fax is 866-686-3539