MidAmerica
Administrative & Retirement Solutions
P.O. 24927 Lakeland, FL 33802
855.329.0095 ♦ Fax 863.577.4460 ♦ www.midamerica.biz

Health Reimbursement Arrangement (HRA)
Flexible Spending Account (FSA)

Authorization for Release of Protected Health Information

Participant Name: _____

Social Security Number: _____

I authorize MidAmerica Administrative & Retirement Solutions and its business associates to disclose **claims, payment and other related health information about me** (other than psychotherapy notes) to the following persons (select 1-2 persons if desired):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that this authorization will expire when I lose my plan eligibility and am not reinstated. I understand that I have the right to revoke my authorization by advising the plan administrator in writing. This revocation will not be effective to the extent that the authorization has already been relied upon.

I understand that my health information that is disclosed pursuant to this authorization may be disclosed by the persons I have identified above AND I understand that I am not required to sign this form to receive my health care benefits (enrollment, treatment or payment).

Participant Signature: _____ Date Signed: _____

-OR-

☐ I do not want my Health Information released to anyone but myself.

Participant Signature: _____ Date Signed: _____

Please keep a copy of this release form for your records and submit a completed form to:

Mail:
MidAmerica Administrative & Retirement Solutions
Dept: HRA Admin
P.O. Box 24927 Lakeland, FL 33802

Fax:
863-577-4460
Questions?
855-329-0095