GG&A Glynn Griffing & Associates
Professional Service. Personal Care.

P.O. Box 16509
Jackson, MS 39236

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): ______________________________

Verification Contact Method: ☐ Phone ☐ Email (must be your company email)

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Employer Name: ______________________________

Name of Person Being Given Consent: ______________________________

Relationship: ______________________________

Date of Birth: ______________________________

Participant Signature: ______________________ Date: ____________

To protect you, this consent form should be sent from your company/agency email address (or by the contact person for your group) to support@glynn.info.