The Difference Card

HIPAA EMPLOYEE AUTHORIZATION

Except as otherwise permitted or required by applicable federal and state laws and regulations, EB Employee Solutions, LLC. /The Difference Card must obtain an authorization before using or disclosing protected health information ("PHI"). Upon receipt of a valid authorization for its use and/or disclosure of PHI, EB Employee Solutions, LLC. /The Difference Card will make such use and/or disclosure in a manner consistent with such authorization.

DATE: **EMPLOYER/CLIENT NAME:**

EMPLOYEE NAME:
EMPLOYEE ADDRESS:
EMPLOYEE TELEPHONE:

DESCRIPTION OF PHI: A description of the PHI to be used or disclosed:

PERSONS AUTHORIZED TO USE OR DISCLOSE: The person(s), class of persons, or entity to whom EB Employee Solutions, LLC. /The Difference Card is authorized to make the use or disclose:

DESCRIPTION OF EACH PURPOSE TO USE OR DISCLOSE: A description of each purpose of use or disclosure:

EXPIRATION:
This authorization will expire on:

REVOCATION:
I understand that I may revoke this authorization at any time by giving written notice of my revocation to EB Employee Solutions, LLC. /The Difference Card at the address below. I understand that any revocation of this authorization will *not* affect any action EB Employee Solutions, LLC. /The Difference Card took in reliance on this authorization before EB Employee Solutions, LLC. /The Difference Card received my written notice of revocation. I also understand that any revocation of this authorization will not result in my disenrollment from EB Employee Solutions, LLC. /The Difference Card or denial of my eligibility for benefits.

EB Employee Solutions, LLC. /The Difference Card
245 Main Street – Suite 605
White Plains, NY 10601

NOTE THE FOLLOWING:

- As a Difference Card participant, your decision to sign this Authorization is voluntary and said decision will not impact treatment, payment, enrollment or eligibility for benefits under your Difference Card coverage plan.
- The PHI disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by federal and state laws and regulations.

SIGNATURE:
I have read and understand the contents of this document and am hereby providing my agreement to the terms of this Authorization.

SIGNATURE: **DATE:**
PRINT NAME: