

**AUTHORIZATION TO DISCLOSE
PROTECTED HEALTH INFORMATION
TO MY SPOUSE**

Employer: _____

Employee Name: _____

Street: _____

City: _____ State: _____ Zip: _____

Daytime Phone: _____ Email Address: _____

Name of Spouse: _____

I hereby authorize Hirsch Financial Services, Inc. (HFS) to allow my spouse full access to my Medical Flexible Spending Account (FLEX) and/or Healthcare Reimbursement Account (HRA). I authorize HFS to disclose any and all information including my personal medical information, claims information, and fund balance information, as well as any other information held by HFS regarding the administration of the applicable Plan to my spouse.

I understand I can revoke this Authorization in writing at any time. This authorization is to remain in full force and effect until HFS receives written notification from me of its revocation.

Signature: _____ Date: _____

Please contact Hirsch Financial Services, Inc. (HFS) with any questions.

**Hirsch Financial Services, Inc.
P.O. Box 1550 Hunt Valley, MD 21030-1550**

**Phone: 410.771.1331 - Toll-Free: 888.460.8005
Fax: 410.771.5533 - Toll-Free Fax: 888.510.4218**