

**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.  
( 'BcfH 'DUf\_ '8 fJj YZGi JH' ) \$\$Z Hunt Valley, MD 21030  
Phone: 410.771.1331 - Toll-Free: 888.460.8005  
Fax: 410.771.5533 - Toll-Free Fax: 888.510.4218**