HIPAA – PHI Release Authorization

Member SSN

Details of the Individual or Organization you are Granting Authorization To

Name

Date of Birth / / SSN

Address

City, State & Zip

Phone - -

Relationship

Authorize Information to Release

Do you authorize the Plan Administrative Office to speak with this person on your belhalf, and about you and your coverage through this health plan? ◯ Yes ◯ No

◯ Health Plan Information	*Includes information contained in your benefit booklet (i.e. co-payments, coinsurance, eligibility, and other benefit information).*
◯ Premium Information	*Includes information related to billing cycles, bank draft charges, etc.*
◯ Authorization Information	*Includes information regarding pre-certification and authorization, including specific medical information related to requests and determinations.*
◯ Claims Information	*Includes information related to payment of your claims for services you received, including pertinent information located on a claim form (i.e. billed amount, general procedure descriptions, claim payment or denial reasons, etc).*

Right to Revocation

Expiration**:** By default this authorization will expire 365 days from the date the authorization was signed, if you wish this authorization to expire prior to that time please provide such date here: _____.

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice to the OPEH&W Plan Administrative Office. I understand that revocation of this authorization will not affect any action the above named entity took in reliance on this authorization before the above named entity received my written notice of revocation.

Acknowledgement & Signature

I understand that, in accordance with state law, the information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease(s). I understand it cannot be used to disclose Psychotherapy Notes.

I understand that this authorization is voluntary and that the health plan cannot condition my eligibility for benefits, treatment, enrollment, or payment of claims on the signing of this authorization.

I request and authorize the OPEH&W Health Plan to disclose my protected health information as described above. I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.

Employee Signature **Date**

If you are signing as a Power of Attorney, Legal Guardian, Executor or Administrator complete the following and attach a copy of the Legal documents:

Personal Representatives Name Relationship to Individual

This Section for Entity Benefit Coordinator Use Only

Proposed Effective Date / /

Member Name

Entity Name

SEND THE ORIGINAL OF THIS PAGE TO THE PLAN ADMINISTRATOR IMMEDIATELY