PENNSYLVANIA EMPLOYEES BENEFIT TRUST FUND ("THE PEBTF")
MEDICAL PLAN
HIPAA PRIVACY AUTHORIZATION FORM

Authorization for Disclosure of Protected Health Information

Name and information of Individual whose Protected Health Information is the subject of this Authorization:

____

Birth Date: ____________________ Last 4 Numbers Social Security # ☐☐☐☐

____

Street Address Apt #

____

City State ZIP

This Authorization is NOT valid for use or disclosure of Psychotherapy Notes, Genetic Information, the use or disclosure of Protected Health Information for Marketing purposes or for the Sale of Protected Health Information. This authorization DOES grant the person providing information the right to disclose ALL of the personal medical information identified for the purposes described, including, if applicable, information about any diagnosis or treatment for any mental health condition, substance abuse, sexually transmitted disease (such as HIV), cancer, and the manifestation of and effects of a condition that happens to be genetic UNLESS the member expresses to limit any information.

A. I authorize the disclosure of my protected health information (PHI) described below.

Please check all the appropriate boxes describing the PHI you are requesting be disclosed and for PHI not described next to a check box, please check "Other" and describe it in the text box provided.

☐ All Member Information ☐ Financial Information ☐ Eligibility / Benefits

☐ Other – please describe the other information in this box:

B. Person(s) or organization to receive the disclosure of PHI:

I authorize the following to receive the use or disclosure of my PHI described above:

____

Name of Individual/Institution/Organization

____

Street Address Floor- Suite #

____

City State ZIP

C. The purpose for which I am authorizing this use or disclosure is:

Please check a box(s) describing the purpose of the requested use or disclosure. If the purpose is not described next to a check box, please check “Other” and describe it in the text box provided.
“At the request of an individual” is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, state the purpose of the authorization.

☐ At the request of the Individual

☐ Legal Purposes ☐ Personal Use ☐ Insurance Claim

☐ Other – please describe the other information in this box:

D. Expiration Date / Event for this Authorization

This authorization shall be valid - unless I revoke it earlier in writing - until:
Check one box

☐ When Benefits end

or

☐ The following date (has to be a future date): ____

or

☐ When the following event occurs (please describe and provide date):

I understand

1. I may revoke (end) this authorization at any time by giving PEBTF notice of my revocation in writing.
2. My revocation of this authorization will not apply to information used or disclosed as permitted by this authorization before I give PEBTF written notice of my revocation.
3. PEBTF may not condition my treatment or payment, enrollment, or eligibility for benefits on whether I sign this authorization.
4. Information disclosed as permitted by this authorization may be re-disclosed by persons who receive it and is no longer protected by federal health information privacy law.

E. Signature and Date

I (or my Personal Representative on my behalf) have signed this Authorization voluntarily. I have read and understand the content of this Authorization for the Disclosure of Protected Health Information, and that it be in effect and followed beginning on the signature date until it expires or is revoked.

____ ______________________________

Signature, Individual or Personal Representative Date

Personal Representative Name (if applicable) ____

Personal Representative’s Authority to Act ____

(i.e.: parent, guardian, POA, etc)

PEBTF Verification (PEBTF USE ONLY)

☐ Identity of the Individual verified

or if applicable:

☐ Identity, Authority to Act of Personal Representative verified

Confirmed for PEBTF
by:

__________________________________ __________________________________

Signature Printed Name and Title