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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION ("PHI")

Use this form to give GEHA permission to discuss your PHI with the authorized person(s) listed below.

About you, the GEHA member whose PHI may be used or disclosed

Plan ID Number: _____

Member Name: _____ **Date of Birth:** _____

Address: _____

Telephone Number: _____

Please place a check mark in front of each plan you want this Authorization to be applied:

- ☐ GEHA Health Plan
- ☐ GEHA Connection Dental Federal Plan
- ☐ Connection Dental *Plus* Plan
- ☐ CONNECTION Vision Plan

Authorized Use and / or Disclosure

I hereby authorize the Government Employees Health Association, Inc. (GEHA) to (choose one or both as appropriate):

- ☐ use or disclose my PHI as indicated below *TO*:
- ☐ obtain my PHI *FROM*:

Authorized Person #1:

Name: _____ Phone Number: _____

Address: _____

Relationship to You: _____

Authorized Person #2:

Name: _____ Phone Number: _____

Address: _____

Relationship to You: _____

Purpose of Disclosure: _____(reason can be "personal")

Information To Be Used or Disclosed

I authorize the use or disclosure of the following PHI (check the applicable box(es) below):

☐ All of my health information maintained by or on behalf of GEHA, including any mental health, drug/alcohol abuse, or communicable disease treatment records that may be maintained by GEHA.

☐ Only the following records or types of health information:_____

_____

☐ **LIMIT** disclosure to healthcare services provided between the dates: ____/____/____ to ____/____ /____

Term of Authorization

This authorization will expire one year from the date it is signed, unless I specify a date or event of expiration: _____ (expiration date or event). If I terminate from GEHA coverage, I understand this Authorization will terminate automatically.

Important Information About Your Rights

By signing this form, I understand and agree:

- This authorization is voluntary and I may refuse to sign it.
- I may revoke this authorization at any time by notifying GEHA in writing to the address provided on this form. I further understand the revocation will not have any effect on any actions GEHA took before it received the revocation notice.
- I am not required to sign this authorization as a condition to receiving treatment or payment for health care; enrolling in a health plan; or establishing eligibility for benefits.
- The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving person or organization and, upon redisclosure, no longer be protected by federal privacy laws.
- My health information may contain information created by other persons or entities including health care providers and may contain medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information.
- GEHA and GEHA's business associates may disclose my PHI as outlined to the person(s) named for the purpose(s) described above.
- I have had full opportunity to read and consider the content of this Authorization Form.

Signature and Acknowledgement

By signing below, I acknowledge that I have read and understand this Authorization.

Date: _____

Patient or Legal Representative Signature: _____

Relationship to patient: _____
(i.e. parent, legal guardian, power of attorney, etc.)

NOTE: If the signature is not that of the member or the parent when the child is a minor, appropriate legal documentation is required to accept the signature.

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION FORM AFTER YOU SIGN IT.
PLEASE RETAIN A COPY FOR YOUR RECORDS AND RETURN THE ORIGINAL SIGNED AUTHORIZATION FORM TO:

ATTN: Authorization
GEHA
P.O. Box 21542
Eagan, MN 55121
FAX: 816-257-3283