GEHA

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

This form is for subscribers and members covered by the GEHA Health, GEHA Connection Dental Federal, CONNECTION Dental *Plus* plans and/or Connection Vision Plan. Please place a check mark in front of each plan you want this Authorization request to be applied.

NOTE: At least one line MUST be checked for this form to be valid.

- ☐ GEHA Health Plan (includes Connection Vision Plan)
- ☐ GEHA Connection Dental Federal Plan (includes Connection Vision Plan)
- ☐ CONNECTION Dental *Plus* Plan (includes Connection Vision Plan)
- ☐ CONNECTION Vision Plan only

This form is required to state your permission that GEHA employees and GEHA's business associates may discuss or disclose your protected health information to a specific person(s) whom you designate to act on your behalf. Each person in your family must complete his or her own form.

NOTE: ALL AREAS OF THIS FORM MUST BE COMPLETED IN FULL. INCOMPLETE FORMS WILL BE CONSIDERED INVALID AND RETURNED. (This form does not permit the authorized person to change any information on file at GEHA for the patient, such as address, phone number, name, etc.)

Section A: Subscriber/Member Information

Subscriber Name: _____

Address: _____

Subscriber ID Number: _____ Telephone Number: _____

Patient Name: _____ Date of Birth: _____

Section B: Type of Information to be Disclosed

- Protected Health Information (which is personally identifiable information), including, but not limited to, identification of treating providers of care, diagnosis, procedures, demographic information (vital statistics such as address, age, etc.), claims, appeals, overpayments, enrollment.

Please check the appropriate box in regard to the protected health information to be disclosed by GEHA:

1. If you would like all information available at the request of the person you have authorized:

☐ All information maintained by GEHA, including any mental health, drug/alcohol abuse, or communicable disease treatment records that may be maintained by GEHA.
(If this option is selected, DO NOT select any other option)

☐ All information maintained by GEHA **EXCLUDING** any mental health, drug/alcohol abuse, or communicable disease treatment records that may be maintained by GEHA.
(If this option is selected, DO NOT select any other option)

2. If you would like the information available at the request of the person you have authorized to be limited:

☐ One time release of information to verify health insurance for purpose of subsidized housing, agency assistance for medical care or public assistance, etc.

Note: This is a one time release of information specifically requested, which may include enrollment data, premiums, claim dollars paid, etc. Completion of an authorization form is required every time this type of information is requested.

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

☐ **LIMIT** information to (Explain in detail): _____

_____

Section C: Authorized Use and / or Disclosure

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

Authorized Person #1:

Name: _____ Phone Number: _____

Address: _____

Relationship to You: _____

Authorized Person #2:

Name: _____ Phone Number: _____

Address: _____

Relationship to You: _____

Section D: Expiration and Revocation

This authorization will automatically expire two years following the termination of my health plan enrollment, unless I specify a date or event of expiration: _____ (expiration date or event)

Section E: Signature / Authorization

By signing this form, I understand and agree:

- This authorization is voluntary.
- I may revoke this authorization at any time by notifying GEHA in writing to the address provided on this form. I further understand GEHA cannot be held liable for any information released before GEHA received the revocation.
- I understand that if I authorize release of information to others, further disclosure of my health information may no longer be protected by federal privacy laws.
- My health information may contain information created by other person 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.
- By signing this form, I understand and agree that GEHA and GEHA business associates may disclose my protected health information 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.
- GEHA will not condition treatment, payment, enrollment, or eligibility for benefits based on your signature on this form.

I further understand that this will require up to **fifteen (15) working days** from the date received by GEHA to execute this request and forward to GEHA's business associates.

Date:_____ Patient or Legal Representatives Signature: _____

Signer's relationship to patient: _____
(i.e. self, parent, legal guardian, power of attorney, etc.)

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

NOTICE: If you terminate GEHA coverage and re-enroll at any time, a new authorization will be required.

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:

GEHA
ATTN: Authorization
P.O. Box 438
Independence, MO 64051-0438
FAX: 816-257-3283