



Participant SSN _____

PID _____

Authorization for Use or Disclosure of Protected Health Information *(Required by the HIPAA - 45 CFR Parts 160 and 164)*

Authorization Information

I, _____, hereby authorize PEEHIP to disclose the protected health information ("PHI")
Participant Name (printed)

described below to:

Name _____ Relationship _____

by telephone

by email at _____

by mail at _____
Street or P.O. Box City State ZIP Code

Authorization for release of PHI covering the time period **(check one)**:

from *(date)* _____ to *(date)* _____

all past, present, and future periods.

I hereby authorize the release of PHI as follows **(check one)**:

my complete PEEHIP file including records relating to mental health care, communicable disease, HIV or AIDS, and treatment of alcohol/drug abuse

my complete PEEHIP file with the exception of the following information **(check as appropriate)**:

mental health records

communicable diseases (including HIV and AIDS)

alcohol/drug abuse treatment

other *(please specify)* _____

Authorization Certification

This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

This authorization shall be in force and effect until nine (9) months after my death or _____
(date or event) at which time this authorization expires.

I understand that I have the right to revoke this authorization, in writing, at any time by submitting the revocation to PEEHIP. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Sign Here → Participant Signature _____ Date _____

Address _____
Street or P.O. Box City State ZIP Code

Date of Birth _____