



**PEEHIP HIPAA Privacy Authorization**

Retirement Systems of Alabama  
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**Participant SSN**

\_\_\_\_\_|\_\_\_\_\_|\_\_\_\_\_|\_\_\_\_\_|\_\_\_\_\_|\_\_\_\_\_|

**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 \_\_\_\_\_