Retirement Systems of Alabama
PO Box 302150, Montgomery, Alabama 36130-2150
877.517.0020 • 334.517.7000 • www.rsa-al.gov

RSA HIPAA Privacy Authorization

Participant SSN ___ ___ ___ ___ ___ ___ ___ ___ ___

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

Authorization Information

I, _____ (Participant Name (printed)), hereby authorize ☐ ERS ☐ TRS and/or ☐ RSA-1 to disclose the protected health information ("PHI") described below to:

Myself

☐ by email at _____

☐ by mail at _____ (Street or P.O. Box / City / State / ZIP Code)

Name _____ Relationship _____

☐ 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 requested file(s) including records relating to mental health care, communicable disease, HIV or AIDS, and treatment of alcohol/drug abuse

☐ my complete requested file(s) 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. 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 → **Signature of Patient** _____ **Date** _____

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

Date of Birth _____