RSA 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 ❑ ERS ❑ TRS and/or ❑ RSA-1 to disclose the
Participant Name (printed)

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) <u>including</u> records relating to mental health care, communicable disease, HIV or AIDS, and treatment of alcohol/drug abuse

❑ my complete requested file(s) <u>with the exception</u> 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 _____