AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Introduction: As described in the PEBTF's Notice of Privacy Practices, the PEBTF generally may not release information or documents containing the individually identifiable health information of a PEBTF member or dependent to persons not involved with treatment, the payment of health benefits, or the health care operations of the PEBTF unless the PEBTF member or adult dependent signs an Authorization for Release of such information. For example, the PEBTF will generally not share protected health information of a PEBTF member with his or her spouse absent an Authorization.

Such Authorization must identify whom you are authorizing to receive information and describe the information you intend to be disclosed.

Authorization: By my signature below, I hereby authorize the Pennsylvania Employees Benefit Trust Fund (the "PEBTF") to release the information or documentation described below to the person identified below, for the purpose I have indicated:

1. Subject of Information (Individual whose Information is to be Disclosed):

   ☐ Myself Name_____
   Social Security Number_____
   ☐ My dependent child Name of child:_____
   Child's Social Security Number_____

2. Recipient of Information:

   Please release the information or documentation described below to:
   Name of Recipient: _____
   Address: _____
   Telephone No.: _____

3. Documents/Information to be Released (check all that apply)

   ☐ All benefit claims or appeals
   ☐ Specific claims (specify date(s) of service, claim number, etc.)
   _____
   ☐ Billing/enrollment information
   ☐ Other (please specify)
   _____

NOTE: Information regarding the following specially-protected health conditions will not be disclosed unless the box is checked.

   ☐ **HIV/AIDS**
   ☐ **Mental Health**
   ☐ **Substance Abuse**
   ☐ **Psychotherapy Notes**

4. Purpose of Disclosure (explain or indicate "at the request of the individual"):

_____
_____

5. Duration of Authorization (check only one)

- ☐ This Authorization will remain in effect until revoked in writing, pursuant to the procedure set forth below.
- ☐ This Authorization will expire on:_____(insert date)
- ☐ This Authorization will expire upon the following event:_____ (insert occurrence or life event).
- ☐ This Authorization will expire upon the date the individual's coverage for PEBTF benefits ends.
- ☐ This Authorization will expire six months after the date the individual's coverage for PEBTF benefits ends.

I understand that I have the right to revoke this authorization earlier than the date/event set forth above. I understand that any revocation must be in writing and must include my name, address, telephone number, date of this authorization and my signature and that I should send the revocation to:

PENNSYLVANIA EMPLOYEES BENEFIT TRUST FUND
ATTN: PRIVACY OFFICER
150 S. 43RD STREET, SUITE 1
HARRISBURG, PA 17111-5700

I understand that a revocation is not effective to the extent that PEBTF has already released information pursuant to this Authorization and the parties named in this Authorization have relied on the use or disclosure of the protected health information prior to the receipt of the revocation.

I understand that the terms of this Authorization are governed by the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations ("HIPAA"). I understand that the PEBTF generally may not condition payment, enrollment or eligibility for benefits on my execution of this authorization. The law permits the PEBTF to condition enrollment in a health plan or eligibility for benefits on provision of an authorization requested prior to my enrollment in the health plan if:

1. The authorization is sought for the health plan's eligibility or enrollment determinations relating to me or its underwriting or risk rating determinations; and
2. The authorization is not for a use or disclosure of psychotherapy notes.

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the Recipient and, in that case, will no longer be protected by HIPAA.

I have read and considered the contents of this Authorization and I confirm that this form is consistent with my directions.

_____
Signature of Individual or Personal Representative

_____
Description of Personal Representative's Authority

_____
Date of Authorization

INSTRUCTIONS FOR COMPLETION OF AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

In order for the PEBTF to release protected health information pursuant to an authorization, the authorization must be valid. Invalid authorizations cannot be processed. Therefore, it is very important that the authorization be completed correctly. This document describes how to complete the authorization form.

1. "Subject of Information" is the name and Social Security number of the person whose information is to be disclosed.

2. "Recipient of the Information" is the person, classification of person, or entity to whom the information is to be released. Please be sure to include the complete address and telephone number in order to enable the Fund to release the information accurately.

3. "Documents/information to be released" refers to the information that is to be disclosed to the recipient. This description should be specific and meaningful enough to allow the information to be easily identified by the PEBTF. Please be sure to check all boxes that apply. Also, please understand that, unless specific Authorization is provided for information related to HIV/AIDS, Mental Health, Substance Abuse, and Psychotherapy Notes, no information relating to these issues will be disclosed.

4. "Purpose of Disclosure" is the reason that the information is being disclosed. If the individual prefers not to reveal this reason, the indication "at the request of the individual" may be used.

5. "Duration of the Authorization" is the length of time the Authorization is valid. The Authorization must include an expiration date or an expiration event.

6. "Signature of Individual or Personal Representative" requires either the individual who is the subject of the protected health information or his/her personal representative to sign the authorization. A personal representative is someone who has legal authority, as evidenced by a legal document according to state law, to act on behalf of an individual in making decisions related to health care. Personal representatives include parents of unemancipated children, court-appointed guardians; persons appointed in "living wills" or medical directives; and/or executors/administrators of estates. A spouse/domestic partner is not a personal representative unless legal authority, such as a power of attorney, has been granted to act in that capacity. The parent will be considered to be the personal representative of an unemancipated minor child, i.e., under age 21 according to PA law, unless there is a reason why the parent is not the minor child's personal representative (for example, if parental rights were terminated).

7. “Description of Personal Representative’s Authority” means a description of the authority by which a personal representative signs the authorization instead of the individual who is the subject of the protected health information. For example, if a parent is signing on behalf of a minor child, the description of the authority would read, “parent”.

8. “Date of Authorization” is the date that the authorization is granted, usually the date of the signature.