PENNSYLVANIA EMPLOYEES BENEFIT TRUST FUND ("THE PEBTF")
MEDICAL PLAN
HIPAA PRIVACY AUTHORIZATION FORM

Authorization for Disclosure of Protected Health Information

Name of Individual Giving Authorization	Name of Member	Member's Social Security Number
Address of Individual Giving Authorization		Telephone Number

I, the individual identified above, authorize the PEBTF to disclose enrollment, billing, claims, appeals, and other protected health information about me in its possession and control to:

_____("Recipient")

Recipient of Information

This information shall be provided for the purpose of (explain or indicate "at the request of the individual")

_____

***IMPORTANT NOTE: Except as expressly limited, this authorization grants the person providing information the right to disclose ALL of the personal medical information identified for the purposes described, including, if applicable, information about any diagnosis or treatment for any mental health condition, substance abuse, sexually transmitted disease (such as HIV), cancer, and the manifestation of and effects of a condition that happens to be genetic. It does not authorize the disclosure of any other genetic information or psychotherapy notes.**

This authorization shall be in force and effective until (check one):

☐ On (enter date): _____.

☐ When the following event occurs (insert occurrence or life event): _____.

☐ Upon the date the individual's coverage for PEBTF benefits ends.

I understand that:

- I have the right to revoke this authorization at any time by sending such written notification to the PEBTF.
- My revocation will not be effective to the extent that the PEBTF has relied on the authorization before receiving the revocation, but will be effective after it has been received.
- Failure to furnish this authorization will generally not affect my eligibility or enrollment for health coverage or the payment of health benefits. The law permits the PEBTF to condition enrollment in the health plan or eligibility for benefits on provision of an authorization requested prior to my enrollment in the health plan if:
    - The authorization is sought for the health plan's eligibility or enrollment determinations relating to me or its underwriting or risk rating determinations; and
    - The authorization is not for a use or disclosure of psychotherapy notes.
- Once disclosed, the protected health information may no longer be protected by federal or state law and could be disclosed again by my Recipient.

_____ _____

Signature of Individual or Personal Representative **Date**

If a personal representative is signing the form on behalf of the individual whose medical information is to be disclosed, please print the personal representative's name and describe his or her authority to act on behalf of the individual.

Name of Personal Representative	**Authority of Personal Representative**

A fax or photocopy of this form shall be as effective as the original. A copy of this form shall be provided to the authorizing individual.