

Authorization to Release Medical Plan Information

Under federal law, no medical plan, hospital or physician may release certain protected health information (PHI) for uses other than treatment, payment or healthcare operations without authorization. This Authorization Form needs to be completed and signed by a Medical Plan member, spouse, legal guardian or other legal representative to authorize the Board of Pensions to release PHI.

Please note that you only need to submit this form if medical information is needed for a Benefits Plan or Board of Pensions program other than the Medical Plan of the Benefits Plan. All sections must be completed.

1. Whose PHI is it? *(Please print information below and check appropriate box.)*

Name _____ Soc. Sec. # _____

Name of Legal Guardian/Representative (if applicable) _____

Address _____

City _____ State _____ Zip _____ Phone () _____

- Medical Plan member**
 Spouse
 Dependent child

2. Recipient of medical information *(Note: Form cannot be processed if you do not provide recipient's name and address.)*

I authorize the Medical Plan to *(Please check appropriate box AND THEN PRINT RECIPIENT'S NAME AND ADDRESS ON LINES BELOW.)*

- release PHI to a friend, family member, or representative
 release PHI to another Board of Pensions department
 release PHI to my presbytery representative
 release PHI to my spouse
 other _____

Name _____

Address _____

City _____ State _____ Zip _____ Phone () _____

3. Medical information to be released

A. the complete Medical Plan record for services rendered on or after the following date: ____/____/____

B. only the following information: *(Specifically describe the information to be released, including, but not limited to, meaningful descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc.)*

Important note: Unless the authorization is expressly limited, this authorization grants the plan, physician, hospital, or other healthcare provider/organization the right to use or disclose all personal medical information for the purposes described, including medical information about any diagnosis or treatment for mental health, substance abuse, sexually transmitted diseases (such as HIV), cancer and/or genetic conditions.

4. Purpose of authorization

- to permit the Board of Pensions to review Medical Plan issues with recipient identified in Section 2 above.
 other _____

5. Duration of authorization

This authorization will expire on the following date: ____/____/____ or on the occurrence of the following event:

6. Right to revoke authorization

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Board of Pensions at the address below.

7. Acknowledgement of privacy rights

I understand that:

- A revocation is not effective to the extent that 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;
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law; and
- My health plan(s) may not condition payment, enrollment or eligibility for Medical Plan benefits (if applicable), on whether I provide authorization for the requested release of medical information.

I understand that I have the right to:

- Refuse to sign this authorization.
- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights).

I authorize the use of a fax copy or a photocopy of this form.

Name _____

(Print name of Medical Plan member, spouse, or legal representative.)

If legal guardian or other legal representative, please describe nature of authority by checking appropriate box below.

- Natural/adoptive parent
- Guardianship Court Order *(Please attach copy unless previously approved by the Board of Pensions.)*
- Power of Attorney *(Please attach copy unless previously approved by the Board of Pensions.)*
- Other _____

Signature _____

Date _____

(Signature of Medical Plan member, spouse, or legal representative)

Please return your completed Authorization Form to:

Attn: _____

The Board of Pensions of the Presbyterian Church (U.S.A.)

2000 Market Street, Philadelphia, PA 19103-3298

800-773-7752 or 800-PRESPLAN