

- The State Group Insurance Plan ("Plan") cannot use or disclose your health information (or the health information of your children or other people on whose behalf you can act) for certain purposes without your authorization. This form is intended to meet the authorization requirement.
- You must respond to each section and sign and date this form for the authorization to be valid.
- To authorize the use and/or disclosure of any records or documents the Plan may have that were taken by a mental health professional, including a psychiatrist or a psychologist, during a counseling session, you must complete a form for the counseling session records or documents and a separate form for other health information.
- Under HIPAA, you have the right to authorize the release of all information or to describe and limit the information to be released.

Section A: Health Information to be Used or Disclosed.

- Describe in a specific and meaningful way the information to be used or disclosed. Example descriptions include medical records relating to your appendectomy, your laboratory results, and medical records from [date] to [date], or the results of the MRI performed on you in July 1998.

Section B: Purpose(s) for which Information will be Used or Disclosed.

- Describe each purpose for which the information will be used or released. If you initiate the authorization and do not wish to provide a statement of purposes, you may select "at my request."

Section C: Expiration.

- Specify when this authorization will expire. For example, you may state a specific date, a specific period of time following the date you signed this Authorization Form, or the resolution of the dispute for which you've requested assistance.

Signature Line.

- If you are authorizing the release of somebody else's health information, then you must describe your authority to act for the individual.
- Complete and sign this form and send it to:

People First Service Center
PO Box 6830
Tallahassee, FL 32314

Or

FAX: (904) 828-6092

- For help, call (866) 663-4735 or TTY (866) 221-0268, Monday through Friday, from 8:30 a.m. to 5:30 p.m. Eastern Time.

Authorization to Use and/or Disclose Personal Health Information

I. Individual (Name and information of person whose personal health information is being disclosed.)

Name (Print)

People First ID Number

Date of Birth

Complete Mailing Address

Area Code & Telephone Number

II. Authorization and Purpose:

I hereby authorize People First Service Center, on behalf of State Group Insurance Plan ("Plan"), to disclose the health information as described in Sections A-C below. The health information is to be disclosed to or delivered to (as requested):

Name

Complete Mailing Address

Street Address

Area Code & Telephone Number

Section A: Health Information to be Used and/or Disclosed.

Specify the health information to be released and/or used, including (if applicable) the time period(s) to which the information relates. Select only one of the following boxes.

- All of my past, present or future health claims and/or medical records.
- All of my health information relating to Claim Number _____.
- Information regarding prescription drug coverage.
- My health information regarding Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV).
- My health information regarding treatment for alcohol and/or substance abuse.
- My health information regarding behavioral health services, counseling notes or psychiatric or psychological care provided by _____ (Name of individual provider or facility).
- Other (please specify) _____

Section B: Purpose(s) for Which Information will be Used or Disclosed.

Specify each purpose for which the health information described in Section A may be used or disclosed. Select all of the applicable boxes below:

- To facilitate the resolution of a claim dispute
- As part of my application for leave of under the Family and Medical Leave Act (FMLA) or state family leave laws.
- For a disability coverage determination
- At my request
- Other (please specify) _____

Authorization to Use and/or Disclose Personal Health Information

Section C: Expiration of Authorization.

Specify when the Authorization expires. (Provide a date or triggering event related to the use or disclosure of the information.)

- On the following date: _____
- Upon the passage of the following amount of time: _____
- Upon disenrollment from my State-sponsored health plan.
- Upon my return from FMLA leave.
- Other (please specify) _____

III. Your rights:

- You can revoke this Authorization at any time by submitting a written revocation to the address below.
- A revocation will not apply to information that has already been used or disclosed in reliance on the Authorization.
- Once the information has been disclosed pursuant to this Authorization, neither the Plan nor People First has control over the use and distribution by recipient.
- The Plan may not condition Treatment, Payment, Enrollment or Eligibility for benefits on whether I sign the Authorization.
- If this Authorization is requested so the Plan can make an eligibility or enrollment determination, then the Individual may be ineligible for enrollment or benefits if you fail to sign this form. This applies to persons not yet enrolled in the Plan.
- We will provide you a copy of your signed Authorization Form upon request.

IV. Your Authorization:

This form must be signed by the Individual, parent of minor child or the personal representative. The personal representative includes persons with power of attorney, legal guardian, executor or administrator of an estate.

Signature of Individual or Personal Representative Date

If you are signing as a personal representative, attach a copy of your legal documents.

Personal Representative's Name (Print) Relationship to Individual

Personal Representative's Address City State Zip

Personal Representative's Telephone Number

Keep a copy for your records and send the completed form to the following address or fax number:

People First Service Center
PO Box 6830
Tallahassee, FL 32314
(904) 828-6092 Fax