

Authorization to Release Medical Plan Information



THE BOARD OF PENSIONS
OF THE PRESBYTERIAN CHURCH (U.S.A.)

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.

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

Name _____ Last 4 digits of SSN _____

Name of Legal Guardian/Representative *(if applicable)* _____

Address _____

City _____ State _____ ZIP _____ Phone () _____

Medical Plan member Spouse Minor child Adult child

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 my presbytery representative

Release PHI to the Board of Pensions for non Medical Plan use Release PHI to my spouse

Other _____

Name _____

Address _____

City _____ State _____ ZIP _____ Phone () _____

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.

Purpose of authorization

to permit the Board of Pensions to review Medical Plan issues with recipient identified in "Recipient of medical information" section above.

other

Duration of authorization

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

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 on the last page of this form.

Acknowledgment 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; and/or
- 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 above of Medical Plan member, spouse, adult child, 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 (mm/dd/yyyy) _____

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