State Employee & Retiree Health and Welfare Benefits Program
Authorization Form for Release of Records and Information

COMPLETE SECTION A:

A. Identification
This document authorizes the use and/or disclosure of confidential protected health information about the following person:

Name:
_____

Address:_____
_____

Date of Birth: _____

Daytime Phone Number: ( ) _____

Social Security Number: _____

Name(s) of Member(s), If other than Employee/Retiree (your Spouse and/or Dependent Children), about whom information may be used and/or disclosed:
_____
_____

B. Directions for Release
This authorization applies in accordance with my directions as checked below. I authorize the individual or company identified below in Section B.1b to release and/or use protected health information pertaining to the member(s) listed in Section A to the individual or company identified in Section B.1a. I understand that the information to be disclosed and/or used may include enrollment information, eligibility information, premium (payment) information, claims records, claims status, and patient management records, according to my directions.

CHECK ALL THAT APPLY IN SECTIONS B.1a AND B.1b:

B.1a. I authorize the disclosure of information to:

___ Benefits Review Committee
___ Employee Benefits Division
___ My Medical Plan (Name): _____
___ My Dental Plan (Name):_____
___ My Prescription Plan (Name):_____
___ My Physician/Provider (Name):_____
___ My Legal/Personal Representative (Name or describe): _____
_____
___Other (Name or describe):_____

You Must Continue on the Next Page

B.1b. I authorize the obtaining of information <u>from</u>:

___ Benefits Review Committee
___ Employee Benefits Division
___ My Medical Plan (Name):_____
___ My Dental Plan (Name):_____
___ My Prescription Plan (Name):_____
___ My Physician/Provider (Name): _____
___ My Legal/Personal Representative (Name or describe): _____
_____
___ Other (Name or describe): _____

CHECK ALL THAT APPLY IN SECTION B. 2:
B.2. I authorize the disclosure and/or use of the following information:
_____(a) any information related to a specific claim (specify date of service or type of treatment):_____
_____(b) my entire medical record
_____(c) my enrollment, eligibility and premium payment records
_____(d) Other (describe information in detail): _____
_____

CHECK ALL THAT APPLY IN SECTION B.3:
B.3. I authorize the disclosure and/or use for the following reason(s):
_____(a) for review and appeal of a claim denial
_____(b) for assistance with my plan coverages and benefits
_____(c) for assistance with my dependent's plan coverages and benefits
_____(d) for my own purposes
_____(e) Other(describe purposes in detail):_____
_____

READ SECTION C:

C. Right to Revoke:
I understand that I may revoke this Authorization at any time except to the extent that action has already been taken in reliance upon it. If I do not revoke it, this Authorization will expire one (1) year after the date on which the Authorization is signed. To revoke the Authorization, I understand I must contact the following in writing: Employee Benefits Division, HIPAA Privacy Officer, Room 510, 301 W. Preston Street, Baltimore, MD 21201, or via fax to 410-333-7104.

You Must Continue on the Next Page

YOU AND A WITNESS MUST SIGN IN SECTION D:

D. Authorization and Signature: I authorize the release of my confidential protected health information, as described in my directions in Section B. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is covered by Maryland law which prohibits redisclosure or other laws that limit the use and/or disclosure of my confidential protected health information. My treatment, payment, enrollment and eligibility are not conditioned on signing this authorization but the information authorized may be necessary for claim review and appeal purposes.

I,_____, have read the contents of this Authorization, and I confirm that the contents are consistent with my directions. I understand that by signing this form, I am authorizing the use and/or disclosure of my confidential protected health information.

_____ _____
Your Signature Date

_____ _____
Signature of Witness Date

COMPLETE SECTION E FOR A LEGAL/PERSONAL REPRESENTATIVE:

E. Legal Representative: If a Legal Representative (or Parent, Guardian, Conservator, or Authorized Representative) on behalf of the individual signs this authorization, complete the following:

Legal Representative's Name (PRINTED):_____

Legal Representative's Signature:_____

Date:_____ Daytime Phone Number:_____

1. If this authorization is being requested/signed by the Legal Representative, you must furnish a copy of the Power of Attorney or other relevant documents designating you as the representative of the member.
2. Please provide a copy of this form to your authorized representative so that they will be able to establish the validity of their request for your protected health information.

Complete, Sign and Return this form to: Employee Benefits Division, HIPAA Privacy Officer, Room 510, 301 W. Preston Street, Baltimore, MD 21201 or Fax to: 410-333-7104.