Health Benefits Program for State and Local Employees
AUTHORIZATION TO USE AND DISCLOSE
PROTECTED HEALTH INFORMATION

EMPLOYEE/RETIREE

Name: _____

ID Number: _____

MEMBER

Name: _____

Date of Birth: _____ID Number: _____

DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED:

_____

_____

WHO IS AUTHORIZED TO USE OR DISCLOSE THE INFORMATION?

_____

_____

WHO IS AUTHORIZED TO RECEIVE THE INFORMATION?

_____

_____

REASON THE INFORMATION WILL BE USED OR DISCLOSED [if the member initiates the authorization, the statement "at the request of the individual" is sufficient]:

_____

_____

_____

EXPIRATION DATE OR EVENT:

_____

Notice to Member

You may revoke this authorization at any time. To revoke this authorization, send a written statement to the Office of Health Benefits, 12th Floor, Privacy Official, 101 N. Fourteenth St., Richmond VA 23219. The statement must identify this authorization by referring to the date it was signed (below). The statement must include the date on which this authorization is no longer in force.

If you revoke this authorization, we may still use and disclose the information for the purposes listed above, if we have already taken action in reliance on this authorization. Also, if this authorization is to permit disclosure of information to an insurance company, in order for you to obtain insurance coverage, the insurance company may still have the legal right to use the information to contest a claim or to contest your coverage.

You may refuse to sign this authorization. You do not need to sign this authorization to receive health care services.

You do not have to sign this authorization to receive payment, to enroll in Health Benefits Program for State and Local Employees' health benefit plan, or to be eligible for benefits, except:

- If this authorization is sought is for the purpose of determining your eligibility for benefits or enrollment, then you must authorize the Plan to obtain the necessary information or the benefits or enrollment may be denied.
- Under Federal law, you do not have to authorize us to receive the private notes from counseling sessions, which are kept by a mental health professional, as a condition of payment, enrollment in an employee health benefit plan, or eligibility for benefits.

A person or organization that receives your information because of this authorization may have the legal right to disclose this information to other people or organizations without your knowledge or consent.

Signature: _____ Date: _____

If this authorization is signed by someone who is not the member listed at the top of this form, provide a description of the signer's authority to act for the member.

_____

Revised 02/2018