TICUA Benefit Consortium, Inc.

Authorization For Release of Health Information

Purpose of Authorization

A federal statute protects you from unauthorized use or disclosure of your individually identifiable health information. That statute is called the Health Insurance Portability and Accountability Act (HIPAA).

TICUA Benefit Consortium recognizes that you may desire the assistance of your campus Human Resource office with respect to claim issues in the TICUA Benefit Consortium, Inc. Health Plan (the Plan). HIPAA requires an authorization in order for your campus Human Resource office to discuss or assist with the claim or other communication regarding benefits involving individually identifiable health information.

Important Note: You may refuse to sign this Authorization. If you refuse to sign the Authorization, the campus Human Resource office will not be able to discuss the claims or other communication regarding benefits involving individually identifiable health information with you or TICUA Benefit Consortium.

Information About the Use or Disclosure

I hereby authorize the use or disclosure of my individually identifiable health information as described below. *I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the entities providing the information.* **Check the applicable boxes below.**

Patient name: _____ ID Number: _____

A. Persons/organizations authorized to provide the information:

- ❑ TICUA Benefit Consortium
- ❑ Member: _____
- ❑ _____
- ❑ _____
- ❑ _____

B. Persons/organizations authorized to receive the information:

- ❑ TICUA Benefit Consortium
- ❑ Member: _____
- ❑ _____
- ❑ _____
- ❑ _____

C. Specific description of information to be used or disclosed (including date(s)):

- ❑ All health information related to the claims; or
- ❑ Specific information: _____

_____

_____

D. Specific purpose of the disclosure:

- ❑ To allow the Member's Human Resource office to discuss the following identified claims with TICUA Benefit Consortium office and me; or
- ❑ _____

PATIENT NAME	CLAIM NUMBER	PROVIDER	DATE OF SERVICE

E. Will the Health Plan or Health Plan provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above?

No _____ Yes (describe): _____

_____

F. This authorization will expire upon:

- ❑ Resolution of the above referenced claims, but in no event later than _____, 2004 (one year from the date the authorization is signed); or
- ❑ _____

Important Information About Your Rights

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing, but the revocation will not have any affect on any actions the entity took before it received the revocation. (TICUA has provided a place to indicate your revocation at the end of this document.)
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).
- The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving entity. I have the right to seek assurances from the above-named persons/organizations authorized to receive the information that they will not redisclosed the information to any other party without my further authorization.

Signature of Patient or Patient's Representative

_____ _____

Signature of patient or patient's representative **Date**
(Form MUST be completed before signing.)

Printed name of the patient's personal representative: _____

Relationship to the patient, including authority for status as representative: _____

PLEASE PROVIDE COPY OF DOCUMENT DESIGNATING REPRESENTATIVE STATUS

Revocation of Authorization

I hereby revoke the above Authorization:

_____ _____

Signature of patient or patient's representative **Date**

1 copy to ***TICUA Benefit Consortium***
1 copy to ***Member***
1 copy to ***Patient***