HIPAA AUTHORIZATION: FOR USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

OPERS
Ohio Public Employees Retirement System
277 East Town Street, Columbus, Ohio 43215-4642
1-800-222-PERS (7377)
www.opers.org

Use this form to authorize the disclosure of information related to a benefit recipient's participation in an OPERS health plan, including a Health Reimbursement Arrangement account. The form alone does not authorize the disclosure of Protected Health Information. **You or the third party must contact OPERS separately to request specific information under the authorization.** This form will not authorize the release of retirement account information. If you wish to authorize release of your retirement account information, please contact OPERS to request an *Authorization to Release Account Information* form.

STEP 1: Participant's Personal Information

Participant's First Name | MI | Last Name

Participant's Social Security Number — — **-OR-** Participant's OPERS ID

Participant's Date of Birth
Month / Day / Year

STEP 2: Authorization Disclosure

1. Protected Health Information to be disclosed - This information will only be disclosed when you or the third party contact OPERS to request specific PHI. Select the information you are authorizing OPERS to disclose to the third party.

☐ Plan eligibility, plan participation, including pre-Medicare group coverage, dental, vision, Member-Directed Plan RMA, Wellness RMA, Heath Reimbursement Arrangement

☐ Health care enrollment and coverage information, including covered individuals, monthly premium, allowance amount, direct billing

☐ Other - Describe, fully, the information that is the subject of this authorization and which OPERS is permitted to disclose.

_____

_____

_____

2. If you are the personal representative of the participant, describe the scope of your authority to act on the participant's behalf, and provide supporting documentation (e.g. Power of Attorney, Letters of Guardianship):

_____

STEP 2: Authorization Disclosure *(continued)*

3. The Plan may disclose the participant's Protected Health Information, which is described above, to the following person(s) or group of persons. If you wish to designate more than this section allows, list them on a separate sheet of paper and include their name and address. If you are using additional pages, please check this box. ☐

First Name MI Last Name

Street or Mailing Address

City State ZIP Code

Phone Number Fax Number

4. I understand if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

5. This authorization is valid:

☐ For 60 days ☐ For 90 days ☐ Until: Month / Day / Year

If no end date is provided, this authorization will expire one year from the date the form is signed.

6. I understand I may revoke this authorization in writing at any time, prior to the termination date or event set forth in paragraph 5, except to the extent the action has been taken by the Plan in reliance on this authorization, by sending a written revocation to the HIPAA Privacy Officer at 277 E. Town St., Columbus, OH 43215.

STEP 3: Acknowledgment

I hereby authorize the disclosure of Protected Health Information as described in Step 3 above.

Participant or Personal Representative Signature:

_____ Today's Date ____/____/____

Do not print or type name