STATE OF WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE AGENCY

PHI

601 57th Street SE • Suite 2 • Charleston WV 25304 (304) 558-7850

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Policyholder or Dependent Name:		Date of Birth:
Telephone Number:	Policyholder ID Number (See insurance card): 7700 _ _ _ _ _ _	
Address:		
City:	State:	Zip
Specific description of the information you wish to be disclosed **(Place your initials beside the documents you wish to be released):** _____ All information _____ Medical Claims information _____ Prescription Claims information _____ Eligibility information _____ Other (specify dates, if necessary): _____		
Who do you authorize to disclose the information described above? **(CHECK ALL THAT APPLY)** _____ Public Employees Insurance Agency _____ UMR TPA (Medical Claims) _____ Express Scripts (Prescription Claims) _____ Other _____	Who is permitted to receive the information you have authorized for disclosure: _____	Please list the purpose(s) of the disclosure: _____ At my request _____ Other _____

When do you want this authorization to expire? _____ No expiration date

_____ Specify date or event that will prompt expiration _____

Notice to Member

You may revoke this authorization at any time. To revoke this authorization, send a written statement to the *PEIA Privacy Officer, 601 57th Street SE, Suite 2, Charleston, WV 25304.* 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 The statement must include the date on which this authorization is no longer in force.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 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 EXCEPT in the following circumstances:

- If the only purpose for providing you with a service is to obtain health information to disclose to someone else, then you must authorize that disclosure in order to receive the service.
- If the services are related to research, you may be required to authorize the use or disclosure of your health information for the research. This applies only to health information related to the research services. The use and disclosure of your information will be limited to what is necessary for the research. If you do not authorize the use and disclosure of your information for the research, you may not be eligible to receive the services.

You do not have to sign this authorization to receive payment, to enroll in PEIA's health plan, or to be eligible for benefits, EXCEPT:

- If this authorization is sought for the purpose of determining your eligibility for benefits or enrollment, then you must authorize PEIA to obtain the necessary information or the benefits or enrollment may be denied.
- If this authorization is sought for the purpose of underwriting or risk rating determinations, then you must authorize PEIA to obtain the necessary information or benefits or enrollment may be denied.
- Under Federal law, you do not have to authorize us to receive the private notes from counseling sessions that are kept by a mental health professional, as a condition of payment, enrollment in a health 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 policyholder or dependent listed at the top of this form, provide documentation of the signer's authority to act for the member.

The policyholder or dependent will be provided with one copy of this form unless he or she initiates the authorization.