

STATE OF DELAWARE
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION
FROM THE DELAWARE EMPLOYEE HEALTH CARE PLAN
[PLEASE CHECK THE APPROPRIATE BOXES AND FILL-IN THE BLANKS]

Part 1: Name of person whose health information will be disclosed: *[please print]:*

Part 2: Person or Entity that has the health information to be released:

State of Delaware Employee Health Care Plan *(as defined in State of Delaware's Privacy Policy)*
(known as the "Plan")

Part 3: Description of the health information to be released:

Information related to my eligibility for benefits for the period from _____ *[fill in date]* to _____ *[fill in date]*. If relevant, please specify types of information:

Information related to my claims for the following illness or injury: _____, for the period from _____ *[fill in date]* to _____ *[fill in date]*. If relevant, please specify types of information:

Information relating to payment or lack of payment for services or items to _____ *[print the name of health care provider]* for services or items rendered during the period from _____ *[fill in date]* to _____ *[fill in date]*. If relevant, please specify types of information:

Describe information to be released, including any applicable time limitations:

[Please note that the types of information maintained by the Plan include: explanation of benefits (EOB) forms, claims history, eligibility determinations, information related to payment of claims or coordination of benefits, medical records obtained and/or reviewed with regard to claims or appeals, and other information that the Plan may have used to make decisions about your eligibility for benefits or the payment of your claims.]

Part 4: Person or Entity that will receive the health information:

State of Delaware _____
[please print the name, title and address of person that will receive the information]

State of Delaware non-health plan: _____
[please print the name of non-health plan that will receive this information, such as Disability Insurance, Workers Compensation Program, Life Insurance, as well as the name or title and address of person that will receive this information]

Family Member or Friend:

_____ [please print name and address of family member or friend who will receive the information]

Other: _____

_____ [please print the name and address of the entity or person that will receive the information]

Part 5: Description of the purpose for the release of the health information:

At the request of the person whose name appears in Box 1

To obtain assistance with the processing, payment and/or adjudication of pending Plan claims

To support a claim for non-health benefits, such as disability benefits, workers compensation benefits or life insurance benefits

Other [insert description of the purpose]: _____

Part 6: Duration of Authorization: This Authorization will remain effective [choose an expiration period or event]:

Expiration period: 30 days 60 days 90 days 180 days ___ days

Expiration event: _____ [insert description of an event upon which the Authorization will expire]:

Part 7: Certification and Acknowledgement: I certify that I am the person (or the personal representative of the person) designated in Part 1. I agree that my individually identifiable health information described in Part 3, and held by the person or entity listed in Part 2, may be disclosed to the person or entity listed in Part 4 for the purpose(s) designated in Part 5.

I understand that the State of Delaware Employee Health Care Plan will not condition treatment, payment, enrollment or eligibility on the provision of this Authorization. I understand that I have the right to revoke this Authorization, in writing, at any time, by sending the revocation to the State of Delaware Employee Health Care Plan, Privacy Officer, 500 W. Loockerman St., Suite 320, Dover, Delaware, 19904, and that the revocation will be effective except to the extent that the Delaware Employee Health Care Plan has already taken action in reliance on my Authorization. I understand that, once disclosed, it is possible that the health information may be further disclosed by the recipient and no longer subject to protection under federal privacy rules. ***I have received a copy of my signed Authorization.***

Signature: _____ **Date:** _____

Member ID number: _____ **Daytime Telephone:** _____

[If signing as the personal representative of the person in Box 1, print your name and describe your authority to sign for the person]:

Name: _____

Authority: _____

For office use:

Authorization fully completed and signed

Copy of Authorization provided to Individual or Personal Representative