RESET

STATE OF TENNESSEE GROUP INSURANCE PROGRAM

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION AND APPOINTMENT OF PERSONAL REPRESENTATIVE

State of Tennessee • Department of Finance and Administration • Benefits Administration
312 Rosa L. Parks Avenue, 19th Floor • Nashville, TN 37243 • 615.770.6949 • 866.252.1523 • FAX: 615.253.8556

Purpose: This form should be used to allow Benefits Administration, the division of Finance and Administration that manages your state provided insurance plan, to disclose protected health information to another individual or entity to carry out activities not covered in the Notice of Privacy Practices of the State Group Insurance Program.

SECTION A: THE INDIVIDUAL FROM WHOM THIS AUTHORIZATION OR APPOINTMENT IS BEING REQUESTED

*Name: _____

*Address: _____

Phone: _____ Email: _____

*Edison ID (if you do not have an Edison ID, please provide your SSN): _____

*❑ I am the Plan Member ❑ I am the Parent/Guardian of the Plan Member ❑ I am the Plan Member's Personal Representative

Appointment of Personal Representative (if applicable). I appoint the individual named below to act on my behalf as Personal Representative with regard to (check all that apply):

❑ Inquiries and claims for healthcare and other benefits
❑ Inquiries and claims for healthcare and other benefits limited to the following: _____
❑ Inquiries and claims for healthcare and other benefits on or after the effective date of this appointment

Personal Representative's Name: _____

SECTION B: PLEASE READ AND COMPLETE THE FOLLOWING STATEMENTS CAREFULLY

***Purpose of this Authorization.** You are authorizing Benefits Administration to release your protected health information for the following purpose (for example: for assistance with my healthcare coverage benefits, to get health treatment, for court, for work or for your personal use):

_____

_____

***To whom can Benefits Administration release my information?** You are authorizing Benefits Administration to release your Protected Health Information to the following indiviidual(s) or entity:

_____

_____

Psychotherapy Notes: If this authorization if for psychotherapy notes, you CANNOT use it as an authorization with any other type of protected health information

❑ Check if this authorization is for psychotherapy notes

***What health information can we disclose?** (Check all that apply)

- ❑ Benefits Administration Insurance Records
- ❑ My records pertaining to my retirement
- ❑ My records pertaining to FMLA
- ❑ My records pertaining to COBRA
- ❑ My records pertaining to the ParTNers Health & Wellness Center
- ❑ Other reason: _____
  (be specific, we will only share the health information you tell us we can share)

No Conditions: This authorization is voluntary. We will not condition our payment activities in connection with your claims, your enrollment in our health plan or your eligibility for benefits on you giving this authorization.

***Expiration:** This authorization will expire. Choose an expiration date or give an expiration event that relates to the purpose of this release (i.e., when I retire, if I am terminated or resign my position, when litigation ends or after my surgery is approved).

- ❑ On ____/____/_____
- ❑ On occurrence of the following event: _____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to Benefits Administration. I understand that revocation of this authorization WILL NOT affect any action taken in reliance on this authorization before you received my written notice of revocation. Revocations can be mailed or emailed to:

Benefits Administration
HIPAA Privacy and Security Officer
312 Rosa Parks Avenue
1900 W.R.S. Tennessee Tower
Nashville, TN 37243
benefits.privacy@tn.gov

****IMPORTANT**** If you chose to use electronic communications there is a risk. Confidentiality of information sent via the internet cannot be guaranteed. You may submit this authorization via email, but you do so assuming this risk.

Redisclosure: I understand that information disclosed by this authorization may be subject to redisclosure by the recipient and may no longer be protected under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

SECTION C: SIGNATURE — YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

I, _____, have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization that Benefits Administration may release the protected health information described in this form for the purposes stated in this form.

_____ _____

*Plan Member's Signature Date:

Signature of Authorized Representative (if you have one)

Authorized Representative means you have legal proof you can act for this person. An authorized representative signs for a plan member who may not legally sign on his or her own. If the patient is less than 18 years old, a parent or guardian should sign for the minor. **We must have the legal documentation of your appointment on file in our office.**

Personal Representative means you have been appointed by the plan member to act for this person. **We must have an Appointment of Personal Representative on file in our office.**

_____ _____

**Personal/Authorized Representative's Signature Date:

* Required field
**Required if being completed by a Representative

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT