emeriti RETIREMENT HEALTH

HIPAA Authorization

To submit this form, log into your Emeriti RHSP online account at **MyEmeritiHealth.org** and upload using the Secure Message Center or mail to: **Emeriti RHSP, PO Box 4391, Clinton, IA 52733-4391.**

IC25

By completing and submitting this HIPAA Authorization form, I acknowledge, and I hereby authorize the Emeriti RHSP and its authorized agents ("Emeriti") to use and/or disclose my Protected Health Information ("PHI") as described below. I also acknowledge and understand the following:

- This Authorization is voluntary. No individual has coerced me into signing this Authorization, and I am providing this Authorization of my own free will.
- Once any of my PHI is received by the authorized person(s) listed in Section 2 below, it may then be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws.
- The Emeriti RHSP is not responsible for ensuring that any recipient of my PHI (in accordance with this Authorization) will further use and/or disclose the information for the purposes listed below.
- I have the right to revoke this Authorization at any time by sending a written request to the Emeriti RHSP. The revocation will not affect any actions taken by the Emeriti RHSP prior to receiving my revocation. **For more information on how to revoke this Authorization, please contact us at 1-866-363-7484.**
- Unless otherwise revoked, this Authorization will expire upon my death.
- The person listed in Section 2 below may not condition treatment, payment, enrollment, or eligibility for benefits on my executing this Authorization.

1 Participant and Account Information (Please fill out your information below)

Account Number or SSN: _____ Date of Birth: _____

First Name: _____ Last Name: _____

2 Authorization for the Release of Protected Health Information

A. The following person is authorized to receive, use, and or disclose my PHI:

Authorized Contact: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Email: _____

B. The following is a description of the PHI the Plan is authorized to disclose to the person(s) listed above:

_____

Please specifically and meaningfully describe the PHI to be disclosed. Details should include dates and conditions, if applicable. Your description must be specific enough so that the person receiving the Authorization can clearly understand which information this Authorization is intended to cover. You may authorize disclosure of your entire medical record by writing "all health information."

C. The purpose of this disclosure is: (Optional)

_____

3 Required Authorizing Signature

By signing the below, I acknowledge and affirm the statements in this HIPAA Authorization form.

Sign Here _____ _____ _____

Participant Signature **Date** **Phone Number**

If this Authorization is signed by a person with authority to act on behalf of the Participant, please complete the following information. You must also attach the appropriate documentation demonstrating your authority to act on behalf of the Participant (e.g., Power of Attorney, Guardianship, etc.).

Sign Here _____ _____ _____

Signature of Authorized Representative **Date** **Phone Number**

Questions? 1-866-EMERITI (1-866-363-7484)