SAG-AFTRA HEALTH PLAN

3601 W. Olive Ave., Burbank, CA 91505 • Mailing Address: P.O. Box 7830, Burbank, CA 91510-7830
P (800) 777-4013 • F (818) 953-9880 • www.sagaftraplans.org/health

Authorization for Release of Health Information Form

- Send the completed, signed and dated form to the privacy officer at the mailing address above.
- The SAG-AFTRA Health Plan (Plan) is required to have a separate form signed by each individual covered by the Plan age 18 and over.
- This form does not serve as a change-of-address form.

Participant: _____

Participant Social Security number (SSN): _____ - _____ - _____

Patient (if different than participant): _____

This individual authorizes the release of his/her Protected Health Information (PHI).

(Check only one box): ☐ Participant ☐ Spouse ☐ Dependent (18 or older) ☐ Dependent (under 18)

Current address (street, city, state, zip): _____

_____ _____ _____
Daytime phone Home phone Email

1. Health information to be disclosed or used (check only one box)

☐ Any and all information maintained by the Plan

☐ Release only specific information related to ☐ eligibility/enrollment ☐ claims records ☐ claims status

☐ Other (describe the specific health information you authorize the Plan to disclose): _____

2. Health information to be disclosed for the following specific purpose(s):

☐ Medical care ☐ Legal investigations or action

☐ Insurance/eligibility and benefits ☐ At my personal request

3. Name(s) and address(es) of person(s) or organization(s) authorized to receive the information. I understand that after this information is disclosed, federal law might not protect it. More information is on the next page of this form.

_____
Full name Address

_____
Full name Address

4. This authorization shall expire (check only one box)

☐ On: _____(mm/dd/yyyy) (Must be a future date, not the date in the signature line)

☐ Upon the occurrence of the following event related to my health care or to the purpose for which I have authorized the use and/or disclosure described in section 2 above: _____

Important: If no box is checked, this authorization will expire two years after the date when this form was signed.

5. Signature of participant/patient (if not participant)

By signing this authorization, I authorize the Plan to disclose my protected health information (PHI) to the person(s) or organization(s) listed in section 3. I have signed this authorization voluntarily to document my wishes regarding the disclosure of the health information described in sections 1 and 2 of this form, and acknowledge that I have read and understand my rights described in section 7.

_____
Signature of participant, spouse, dependent (age 18 or older) or parent of dependent (if under age 18) Date

6. If a personal representative is executing this form, please provide an explanation and documentation supporting his/her authority to sign on behalf of the participant/patient. ☐ Check if documentation is attached.

_____ _____ _____
Personal representative (print) Signature of personal representative Relationship to participant/patient

The *Authorization for Release of Health Information Form* is required for release of protected health information (PHI) in compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. This form authorizes the SAG-AFTRA Health Plan (Plan) to disclose your health information to the person(s) and/or organizations you designate. If the person(s) and/or organization(s) listed in section 3 are not covered entities subject to federal privacy standards, the health information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards and such person(s) and/or organization(s) may re-disclose my health information without obtaining my authorization.

7. Your rights regarding this authorization

- Right to revoke. You have the right to revoke this authorization at any time. Your revocation of this authorization must be in writing. To obtain a copy of an *Authorization Revocation Form* you may contact the Plan at the address listed below. Your revocation will not affect the disclosures of your PHI that have already been made according to this authorization to the person(s) and/or organization(s) identified in section 3 of this authorization. I understand that after this information is disclosed, federal law might not protect it.
- Right to receive copy of this authorization. I understand I have the right to receive a copy of this authorization by contacting the privacy officer.
- For an *Authorization Form* or a *Revocation Form* contact: Privacy Officer, SAG-AFTRA Health Plan, P. O. Box 7830, Burbank, CA 91510-7830