Authorization to Disclose HealthChoice Information

HealthChoice is the plan administered by the Office of Management and Enterprise Services Employees Group Insurance Division.

1. Member information

Name _____ Member SSN/ID # _____

2. Individual information (the person whose information will be shared)

Name _____ SSN _____

Date of Birth _____ Phone (____) _____

Address _____

3. Person giving authorization (if different from #2 above)

Name _____ Relationship _____

Address _____ Phone (____)_____

4. Person/Organization receiving information

Name _____ Relationship _____

Address _____ Phone (____) _____

Fax (____) _____

5. For the specific purpose(s)

_____

6. Specific information to be disclosed

_____

7. Expiration and Revocation

This authorization will expire (must choose one):

___ Upon termination of enrollment in the HealthChoice plan.

___ 12 months from the signature date.

___ Upon the minor's age of majority.

___ Other (insert date or event): _____

I understand an authorization to use or share protected health information remains valid until termination of the member's or dependent's enrollment in HealthChoice, unless a shorter period of time is specified, or unless rescinded. I also understand I can revoke this authorization at any time by signing a "Revocation of Authorization to Disclose HealthChoice Information" form, which will be provided to me by HealthChoice upon request. I further understand any action taken on this authorization prior to the rescinded date is legal and binding and, if this authorization is used by EGID, no compensation is payable to EGID for this authorization.

I understand my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by federal or state substance abuse confidentiality regulations, the recipient cannot re-disclose such information without my further written authorization unless otherwise provided for by state or federal law. I understand the information authorized for release may include records which may indicate the presence of a communicable or noncommunicable disease.

I also understand I can refuse to sign this authorization, and my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treating provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

By signing this form, I understand and agree I am responsible for any fees charged for copies of medical information or records provided by any entity, and EGID is not responsible for payment of any fees charged for copies of medical records, reports or any other documentation.

I further understand that I can request a copy of this signed authorization.

Return to EGID, 3545 N.W. 58th St., Ste. 600, Oklahoma City, OK 73112

8. Signature of member, legal representative, spouse, parent, or dependent age 18 or over and date.

Signature: _____ Date: _____

Instructions for Authorization to Disclose HealthChoice Information

1. Enter the member's name and Social Security number/HealthChoice ID number.
2. Enter the name, Social Security number, date of birth, phone number and address of the person whose information will be shared.
3. If the member providing this authorization is the same individual whose information will be shared, this section should remain blank. However, if the individual whose information will be shared is incapacitated or under 18 years of age, enter the name, relationship, address and phone number of the legal representative or parent providing the authorization to release information.
4. Enter the name, address, phone number and fax number of the entity authorized to receive the information.
5. Enter the purpose for which the information is to be used.
6. Enter the specific information to be released.
7. Check or enter the date, event or condition that the authorization is to expire.
8. Member, legal representative, spouse, parent or dependent age 18 or over must sign and date the authorization form.