GEHA

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO A THIRD PARTY

About You

Plan ID Number: _____

Your Name: _____ **Date of Birth:** _____

Address: _____

Telephone Number: _____

Please place a check mark in front of each plan you want this Authorization to Disclose to be applied:

- ☐ GEHA Health Plan
- ☐ Connection Dental *Plus* Plan
- ☐ GEHA Connection Dental Federal Plan
- ☐ CONNECTION Vision Plan

Authorized Person or Company Who Will Receive this Information

I authorize my health plan carrier, **Government Employees Health Association, Inc. (GEHA)**, to disclose my individually identifiable health records to the following third party as described below:

Name: _____

Address: _____

Purpose of Disclosure: _____(reason can be "personal")

Information to be Released

I authorize GEHA to disclose my claims and medical information as follows:

- ☐ Limit disclosure to all healthcare information, **EXCLUDING** any mental health, drug/alcohol abuse, or communicable disease treatment records that may be maintained by GEHA.
- ☐ Limit disclosure to Benefit / Coverage information.
- ☐ Limit disclosure to healthcare services provided between the dates: ____/____/____ to ____/____ /____
- ☐ All healthcare information including any mental health, drug/alcohol abuse, or communicable disease treatment records that may be maintained by GEHA.
- ☐ Other (specify) _____

Important Information About Your Rights

- This authorization is voluntary and will automatically expire upon disclosure of the requested records.
- I may revoke this authorization at any time by notifying GEHA in writing to the address provided on this form.
- I further understand the revocation will not have any effect on any actions GEHA took before it received the revocation notice.
- I am not required to sign this authorization as a condition to receiving treatment or payment for health care; enrolling in a health plan; or establishing eligibility for benefits.
- The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving person or organization and, upon redisclosure, no longer be protected by federal privacy laws.
- My health information may contain information created by other person or entities including health care providers and may contain medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information.
- By signing this form, I understand and agree that GEHA and GEHA business associates may disclose my protected health information as outlined to the person(s) named for the purpose(s) described above.
- I have had full opportunity to read and consider the content of this Authorization Form.

Signature and Acknowledgement

By signing below, I acknowledge that I have read and understand this Authorization.

Date: _____

Patient or Legal Representative Signature: _____

Relationship to patient: _____
(i.e. parent, legal guardian, power of attorney, etc.)

NOTE: If the signature is not that of the member or the parent when the child is a minor, appropriate legal documentation is required to accept the signature.

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION FORM AFTER YOU SIGN IT.
PLEASE RETAIN A COPY FOR YOUR RECORDS AND RETURN THE ORIGINAL SIGNED AUTHORIZATION FORM TO:

ATTN: Authorization
GEHA
Records Management Office
201 NE Mulberry St.
Lee's Summit, MO 64086
FAX: 816-257-3207