AGC Health Benefit Trust

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

This Authorization is required for the Trust to release your health information to someone other than yourself or for purposes outside the Trust's normal operations (treatment, payment of claims or healthcare operations). Please read the following information carefully and complete the requested information below.

Name of Person whose health information will be disclosed: _____

Date of Birth: _____/_____/_____ Last 4 digits of Social Security Number: _____

Address: _____

Phone Number: _____ Email address: _____

I AUTHORIZE AGC Health Benefits Trust to DISCLOSE my health information TO THE FOLLOWING person(s) or organization(s) _____

At the following address: _____

NATURE OF INFORMATION TO BE DISCLOSED

1. **Describe the Information to be Disclosed:** Identify what information you authorize to be used or disclosed. The information should be specific such as "All health records on file", or "Information related to my knee surgery"
   _____

   For the date(s): _____ If no dates are specified the last 2 years will be provided

The following classes of information are protected by special privacy laws and access may be subject to special rules or may be restricted under certain circumstances. **If you are requesting access to records related to any of the following,** additional authorization is required. **Please initial each applicable item below to confirm your request.**

_____ Mental health information Initial

_____ Substance abuse treatment information Initial

_____ HIV lab test results Initial

2. **Describe the purpose or limitations of the requested use or disclosure:**
   - ☐ At the request of the individual or personal representative for personal use; OR
   - ☐ To a healthcare provider for continuation of care; OR
   - ☐ Other: _____

   I request that my health care records be delivered in the following format (choose one):
   - ☐ Paper
   - ☐ Electronic Delivery (fastest format) Please provide email address _____
   - ☐ Other: _____

EXPIRATION: This authorization will automatically expire one (1) year from the date of execution unless a different end date is specified here: _____

MY RIGHTS:

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
- I may revoke this authorization at any time, but I must do so in writing and submit to Pacific Central Coast Health Center. My revocation will take effect upon receipt, except to the extent that others have taken action in reliance upon this authorization.
- I have a right to receive a copy of this authorization
- Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases may no longer be protected by federal confidentiality law (HIPAA).

Signature: _____ Date: _____
(Patient or personal representative)

PERSONAL REPRESENTATIVE

This section only needs to be completed if this authorization is being completed by someone as a personal representative of the individual to whom the health information relates.

The Trust, for purposes of the Privacy Rule will treat a properly designated personal representative as the individual for purposes of the Privacy Rule. This will apply when the individual is deceased, the personal representative has been designated in accordance with applicable law, or in the case of unemancipated minors, an authorization is required as a result of state law. The Trust reserves the right to decline to recognize an individual as a personal representative if there is a reasonable belief that the individual whose information would be disclosed has been or could be subject to abuse, neglect or endangerment by disclosure. Disclosure also will not be made if inconsistent with applicable law.

Except as limited by state law or the Privacy Rules, no authorization is needed to disclose information to a natural parent or legal guardian of an unemancipated minor.

_____ _____
Print name of personal representative Relationship to individual

Basis for being Personal Representative (e.g., legal guardian, executed health care power of attorney, etc.):

_____
Attach documentation establishing your authority to act for the named individual.

Address: _____

Phone Number: _____ Email address: _____

Signature: _____ Date: _____

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Internal Use Only:

- ☐ Identification verified for individual and/or personal representative
- ☐ Authorization reviewed and approved by _____
- ☐ Health Information disclosed date _____
- ☐ Signature of person who sent health information _____
- ☐ Scanned and uploaded to Simon