HealthSCOPE BENEFITS

Authorization for the Use and Disclosure of Individually Identifiable Health Information

PURPOSE: This form is used to request an individual's authorization for the use and disclosure of individually identifiable health information.

Egyptian Area Schools

Section A: Individual Granting Authorization	
Covered Employee's Name:	Employee's SSN:
Covered Employee's Employer:	Current Phone :
Name of Individual Making Request:	Individual's SSN:
Current Address:	

Section B: Descriptions	
1. Specific description of information that may be used/disclosed:	
2. The information will be used/disclosed for the following purpose(s):	
3. Persons/organizations authorized to use or disclose the information:	
4. Persons/organizations authorized to receive the information:	
5. Will the persons/organizations authorized to use/disclose the information receive compensation for doing so? Yes ☐ No ☐	
6. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for or coverage of services, or ability to obtain treatment, except as provided in this form.	
7. If the purpose of this authorization is for my claims administrator to determine eligibility before enrollment, the requested use or disclosure is not for psychotherapy notes, and I refuse to sign this authorization , my claims administrator reserves the right to deny enrollment or eligibility for benefits.	
8. If the purpose of this authorization is to disclose health information to another party based on health care that is provided solely to obtain such information, and I refuse to sign this authorization, my claims administrator reserves the right to deny that health care.	
9. If this authorization is being used in connection with a use or disclosure of health information that does not require an authorization under the HIPAA Privacy regulation (e.g. the health information is being used or disclosed in connection with payment or health care operations as defined under the HIPAA Privacy regulations) and I refuse to sign this authorization, I understand that my claims administrator has the right to deny coverage for my medical expenses.	

10. I understand that I may inspect or copy the information used or disclosed.
11. I understand that I may revoke this authorization at any time by giving written notice of my revocation my claims administrator at the address listed below, except to the extent that: (a) action has been taken in reliance on this authorization; or (b) If this authorization is obtain as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.
12. I understand that revocation of this authorization will not affect any action you took in reliance on this authorization before you received my written notice of revocation.
13. This authorization expires on: _____/_____/_____

Section C: Signatures	
Patient's Printed Name:	Date:
Patient's Signature:	Date:
If this request is signed by a personal representative on behalf of the individual, complete the following:	
Patient Representative's Printed Name:	Date:
Patient Representative's Signature:	Date:
Relationship of Representative to Individual:	

Please submit this request to HealthSCOPE Benefits at any of the following addresses:

HIPPA Official
P. O. Box 1224
Little Rock, AR 72203

Or

Customer Care—HIPAA
P. O. Box 16526
Columbus, OH 43216

Or

Customer Care—HIPAA
P. O. Box 50440
Indianapolis, IN 46250

Or

Customer Care-HIPAA
2630 Elm Hill Pike, Suite 203
Nashville, TN 37214

YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM