Authorization to use and/or disclose personal health plan information	
Form received by:	Date:
1. Employee name:	
1a. Employee date of birth:	1b. Health plan ID number:
2. Name of person whose health information is the subject of this authorization:	2a. Relationship to employee: ☐ Self ☐ Spouse ☐ Child ☐ Other (specify relationship):
3. Your name:	3a. If you are not the person in Line 2, describe your authority to act on this person's behalf:
4. Mailing address for records:	4a. City, State, ZIP code:

Section A: Health information to be used and/or disclosed

Specify the health information to be released and/or used, including (if applicable) the time period(s) to which the information relates. Check only one box:

☐ All of my past, present, or future health claims and/or medical records

☐ All of my health information relating to claim number: or care rendered on:

☐ Other (specify):

Section B: Person(s) authorized to use and/or receive information

Specify the person(s) or class of persons authorized to use and/or receive the health information described in Sections A – E:

Authorization to use and/or disclose personal health plan information

Section C: Purpose(s) for which information will be used or disclosed

Specify each purpose for which the health information described in Section A may be used or disclosed. Check all applicable boxes:

- ☐ To facilitate the resolution of a claim dispute
- ☐ As part of my application for leave of under the Family and Medical Leave Act (FMLA) or state family and medical leave laws
- ☐ For a disability coverage determination
- ☐ For sales or marketing activities when the Plan is receiving financial remuneration from a third party
- ☐ At my request
- ☐ Other (*specify*):

Section D: Expiration of authorization

Specify when this authorization expires.

- ☐ On (*specify date*):
- ☐ After (*specify amount of time*):
- ☐ Upon my disenrollment from the Plan
- ☐ Upon my return from FMLA leave
- ☐ Other (*specify*):

Section E: Your rights

You can revoke this authorization at any time by submitting a written revocation to Benefits Services Manager at 350 Spelman Lane Atlanta, GA 30314.

A revocation will not apply to information that has already been used or disclosed in reliance on this authorization.

Once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information will no longer be protected by HIPAA.

The Plan may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign the authorization.

This clause applies to individuals not yet enrolled in the Plan. If this authorization was requested so the Plan can make an eligibility, enrollment, underwriting, or risk-rating determination, then the person in Box 2 may be ineligible for enrollment or benefits if you fail to sign this form.

You will be provided with a copy of this authorization form, after signing, if the Plan sought the authorization.

I hereby authorize the Spelman College Health and Welfare plan ("Plan") to use and/or disclose the health information as described in Sections A – E above.

Signature: Date: