Authorization for Disclosure of Protected Health Information (PHI)

This authorization complies with the HIPAA Privacy Rule

(GuideStone Health Plan Use Only)

Please print.

HEALTH PLAN PARTICIPANT INFORMATION

Name: _____ Social Security number (last four digits): _____

INDIVIDUAL WHOSE PHI WILL BE DISCLOSED

Separate authorization forms are needed from the spouse and dependent children age 18 and older to release their PHI to anyone else, including the participant and GuideStone. The employee can authorize release of their own PHI and of their dependent children under age 18.

Name: _____ Social Security number (last four digits): _____

Address: _____ Telephone number: (_____) _____

1. I,_____, initiate this authorization for disclosure of my PHI. I authorize my Health Plan, its agents and business associates to disclose my PHI as described below. [Statement required by §164.508(c)(1)(ii)]

a) Disclose my PHI to:

Name and address of person or entity to whom we will disclose the information described below. [Statement required by §164.508(c)(1)(iii)]

_____

_____

_____

b) Describe the PHI to be disclosed (check as applicable): [Statement required by §164.508(c)(1)(i)]

☐ Disclose any and all of my PHI requested by the person or entity designated above.

☐ Disclose only the portion of my PHI necessary for the person or entity designated above to act as a claim advocate on my behalf for the following situation:

_____

_____

☐ Other (please describe):

_____

_____

c) Reason for the disclosure (a reason is not required): [Statement required by 164.508(c)(1)(iv)]

_____

2. I understand my PHI may be used or disclosed as set forth by this authorization. PHI includes information created or received by my Health Plan, its agents and business associates. PHI also includes, but is not limited to: [Statement required by §164.508(c)(1)(i)]

- Hospital records
- Treatment records/office notes (including information about sexually transmitted diseases, cancer or genetic conditions)
- Consultation reports
- Alcohol or substance abuse treatment records
- Worker's compensation information
- Diagnosis
- Prescriptions
- Test results
- Vocational testing/counseling information
- Benefit information

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3. I understand that any information disclosed pursuant to this authorization may no longer be covered by the privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and may be subject to re-disclosure by the person or entity to whom it was disclosed. [Statement required by §164.508(c)(2)(iii)]

4. I understand that I may revoke this authorization at any time by sending written notification to:

HIPAA Privacy Contact
GuideStone Financial Resources, SBC
2401 Cedar Springs Road
Dallas, TX 75201-1498
hipaaprivacycontact@GuideStone.org

To obtain a *Withdrawal of Authorization for PHI Disclosure* form, visit GuideStone's website, *www.GuideStone.org*, or call **1-800-262-0511** for assistance from a customer relations specialist. [Statement required by §164.508(c)(2)(i)]

Important note: A revocation is not effective to the extent the parties named in this authorization have relied on the use or disclosure of the PHI. Such revocation shall not apply to any use or disclosure of PHI specifically allowed without authorization by HIPAA, and no action relating to this authorization shall be construed as creating any restriction on the uses and disclosures that HIPAA allows without authorization.

5. This authorization will be valid for (check as applicable):

☐ 24 months following the date of my signature below.

☐ As long as necessary to bring the specific claim or situation described above to a conclusion or 24 months following the date of my signature below, whichever occurs first. [Statement required by §164.508 (c)(1)(v)]

6. I understand that I am not required to sign this authorization form and that my Health Plan will not condition the provision of payment of a medical claim on the signing of this authorization. [Statement required by §164.508(c)(2)(ii)]

I initiate this authorization for disclosure of PHI. I have read and understood this authorization. I know that I may request and receive a copy of it. [Statement required by §164.508(c)(4)] By signing this authorization, I acknowledge that any agreements I have made to restrict my PHI do not apply to the information released pursuant to this authorization. A photocopy of this authorization shall be considered as effective and valid as the original. No alteration of this form will be accepted.

INFORMATION ABOUT THE INDIVIDUAL'S PERSONAL OR LEGAL REPRESENTATIVE, IF APPLICABLE

Name:_____ Relationship: _____

If signing on behalf of another, please include the proper documentation that attests to your ability to sign (death certificate, court-stamped *Letters of Appointment of the Executor of Estate*, proof of custody, power of attorney, etc.). [Statement required by §164.508(c)(1)(vi)]

SIGNATURE OF INDIVIDUAL, COVERED DEPENDENT OR REPRESENTATIVE [STATEMENT REQUIRED BY §164.508(C)(1)(VI)]

Name: _____ Date: _____/_____/_____

Return form to: GuideStone Financial Resources
Insurance Operations
2401 Cedar Springs Road
Dallas, TX 75201-1498

Or you may fax it to: 1-877-834-1025