Ohio Public Employees Retirement System
277 East Town St., Columbus, OH 43215-4642
1-800-222-PERS (7377) www.opers.org

Authorization Form for Uses and Disclosures of Participant Protected Health Information

Section 1 - Participant's Personal Information - *This section is to be completed to gather identifying information on the participant whose protected health information will be used or disclosed.*

Participant's First Name | MI | Last Name

Participant's Date of Birth
Month Day Year

Participant's Social Security Number

Section 2 - Authorization Disclosure

I hereby authorize the use or disclosure of Protected Health Information about me as described below.

1. This authorization was prepared (check if applicable):

☐ At the request of the Participant

☐ Other (describe purpose):

____

____

2. Describe fully the information that is the subject of this authorization and which will be used or disclosed as set forth below:

____

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3. The Plan may release the Participant's Protected Health Information, which is described above, to the following person(s) or group of persons. If you wish to designate more than this section allows, list them on a separate sheet of paper and include their name and address. If you are using additional pages, please check this box. ☐

First Name | MI | Last Name

Street or Mailing Address

City | State | ZIP Code -

Phone Number | Fax Number

HIPAA AUTH (Revised 10/12)

continued on next page

Section 2 - Continued

(step 3 continued)

First Name | **MI** | **Last Name**

Street or Mailing Address

City | **State** | **ZIP Code** -

Phone Number | **Fax Number**

4. If you are the representative of the Participant, describe the scope of your authority to act on the Participant's behalf, and provide supporting documentation relative to your authority to act on behalf of the participant (e.g., Power of Attorney, Letters of Guardianship):

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5. I understand if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

6. This authorization will begin on: **Month** **Day** **Year**

This authorization will end on: **Month** **Day** **Year**

If no end date is provided, this authorization will expire when the participant's enrollment with the Plan is terminated.

7. I understand I may revoke this authorization in writing at any time, prior to the termination date or event set forth in paragraph 6, except to the extent the action has been taken by the Plan in reliance on this authorization, by sending a written revocation to the HIPAA Privacy Officer at 277 E. Town St., Columbus, OH 43215.

Section 3 - Acknowledgment

I understand I am not required to sign this authorization form and the Plan will not condition the provision of payment of coverage to me, or on my behalf, on the signing of this authorization, except that the Plan may condition enrollment in the Plan or eligibility for coverage under the Plan on provision of this authorization, if the authorization sought is for the Plan's eligibility or enrollment determinations relating to me, or for its underwriting or risk rating determinations.

Participant name

Name of personal representative, if applicable

Relationship of personal representative to Participant

Signature of Participant (or Participant's representative)

Month **Day** **Year**