Authorization For Release Of Protected Health Information

charles SCHWAB

This form has been developed in conjunction with HIPAA privacy regulations related to Protected Health Information (PHI). You must complete and return this form before the HR Direct and/or Benefits can assist you with issues regarding your medical, dental, vision, EAP or FSA coverage.

After filling in the form, print, and fax to (602) 355-7961.

Employee/Member Information

Name

Last Name | **First Name** | **Inital**

Employee ID

Covered Member

☐ Employee ☐ Spouse/DP ☐ Child/DP

Covered Member Name(s)

Last Name	First Name

Help Engine Ticket Number (if known)

Authorization Details

I, the undersigned, hereby authorize the use and/or disclosure of the personal health information described below for the indicated purpose:

Information to be Disclosed:
(may be one or more of the following)

- ☐ Application or enrollment information
- ☐ Treatment / claim records / payment records
  For claim issue, indicate:
  Date(s) of service: _____
  Provider(s) name: _____
- ☐ Other (specify):

Persons to Whom the Above Information May be Disclosed:
(list one or more specific persons or class of persons)

- ☐ Schwab Benefits / HR Direct
- ☐ Third party claims administrator:
- ☐ Other (specify):

Purpose of Use and/or Disclosure:
(describe)

- ☐ Use and/or disclosure is being made at my request to resolve the issue indicated above.
- ☐ Other (specify):

Expiration of Authorization:

(unless you specify another date, this Authorization will expire ***six months***

from the date you sign the form)

Declaration

I understand that:

- I have the right to revoke this authorization at any time by notifying the HIPAA Privacy Official (Director, Benefits) in writing (fax: 415/667-0362). Revoking this Authorization will not have any effect on actions taken in reliance on the Authorization before notice of revocation is received.
- Schwab's group health plan may not condition my treatment, payment, enrollment, or eligibility for benefits upon whether I sign this authorization.
- Once my information has been disclosed, as permitted under this authorization, it will no longer be protected under the federal privacy regulations of the Health Insurance Portability and Accountability Act ("HIPAA"), and there is a possibility that the party to whom my information is being disclosed may re-disclose the information without my permission.
- I may review the Schwab group health plan's Notice of Privacy Practices (also available in hard copy by request) before I sign this Authorization.
- I may make and keep a copy of this Authorization.

Covered Member Signature **Date**

☐ Natural or Adoptive Parent of Unemancipated Minor Child

☐ Other Legal Representative (specify):

If this Authorization form is being signed by a legal representative other than a parent of an unemancipated minor child, you must furnish a copy of the health care power of attorney or other legal document designating you as the representative.

Printing Instructions

Click the Print Icon  ***in the toolbar above, or select File-Print***

***Review, sign, and fax to* (602) 355-7961.**

If you do not have access to a fax machine, mail the form to: (for Schwab employees)

HR Direct
Charles Schwab & Co., Inc.
PHXPEAK-02-2H103
2423 E. Lincoln Drive
Phoenix, AZ 85016

Form Owner: **HR Direct** Contact: **HR Direct** **(415-667-8888 or 800-725-3535)** Last updated: **03/25/2008**