



**PUBLIC Employees Health Program**  
 560 East 200 South  
 Salt Lake City, Utah 84102  
 800-765-7347 | 801-366-7555  
 www.PEHP.org

<b>Member Name:</b>	_____
<b>PEHP Member Number:</b>	_____

## Authorization for Disclosure of Medical Information to the Group Term Life Program

<b>WHOSE Records to be Disclosed</b>	
First	Middle
NAME: _____	
Last	
SSN	Birthday (mm/dd/yy)

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange):

**OF WHAT** All my medical records. This includes specific permission to release:

1. All records and other information regarding my medical condition and or treatment, hospitalization, and outpatient care including but not limited to: Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501) drug abuse, alcoholism, or other substance abuse.
2. Information created within 6 months after the date this authorization is signed, as well as past information.

**FROM WHOM** All medical sources (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment and VA health care facilities, health insurers or other organizations and individuals, including but not limited to: Social workers/rehabilitation counselors, Consulting examiners, Employers, and others who may know about my condition.

**TO WHOM** The Group Term Life Program of Public Employees Health Program to process my application including contract copy services, and doctors or other professionals consulted during the process. I further authorize PEHP to disclose any claim information, records, correspondence or other documents necessary for medical case review, study, or claims coordination. I understand that the information, records correspondence or other documents may be provided to independent medical providers, rehabilitation specialists, claims adjusters or other entities who may be involved in the evaluation and processing of this application. I hereby waive any right of confidentiality I may have in these records as it relates to the Group Term Life Program of the Public Employees Health Program.

**PURPOSE** Determining my eligibility for group term life coverage.

**EXPIRES WHEN** This authorization is good for 6 months from the date signed (below my signature).

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances where this information may be re-disclosed to other parties.
- I may write to PEHP and my sources to revoke this authorization at any time (see page 2 for details).
- PEHP will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.

**• I have read both pages of this form and agree to the disclosures above from the types of sources listed.**

<b>Signature of Applicant</b>	
<b>SIGN ▶</b>	Date (Month, day, year)

*This general/and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; and State law.*

**Explanation of Disclosure Authorization Form  
“Authorization to Disclose Information to the Group Term Life Program”**

We need your written authorization to help get the information required to process your application for benefits. Laws and regulations require that sources of personal information have a signed authorization before releasing it to us. Also, laws require specific authorization for the release of information about certain conditions and from educational sources.

You can provide this authorization by signing this form. Federal law permits sources with information about you to release that information if you sign a single authorization to release all your information from all your possible sources. We will make copies of it for each source. A few States, and some individual sources of information, require that the authorization specifically name the source that you authorize to release personal information. In those cases, we may ask you to sign one authorization for each source and we may contact you again if we need you to sign more authorizations.

You have the right to revoke this authorization at any time, except to the extent a source of information has already relied on it to take an action. To revoke, send a written statement to PEHP, ATTN: Group Term Life Program, 560 East 200 South, Salt Lake City, UT 84102. If you do, also send a copy directly to any of your sources that you no longer wish to disclose information about you; PEHP's Group Term Life Program can tell you if we identified any sources you didn't tell us about. Information disclosed prior to revocation may be used by PEHP's Group Term Life Program to decide your application.

**IMPORTANT INFORMATION**

Once medical information is disclosed to Public Employees Health Program, Group Term Life Program, it is no longer protected by the health information privacy provisions of 45 CFR Part 164 (mandated by the Health Insurance Portability and Accountability Act (HIPAA)). At the end of a record's useful life cycle, it is destroyed.

We use the information obtained with this form to determine your eligibility for benefits. This use usually includes review of the information by individuals employed by or contracted by PEHP's Group Term Life Program. In some cases, your information may also be reviewed by PEHP's personnel that process your appeal of a decision or by investigators to resolve allegations of fraud or abuse, and may be used in any related administrative, civil, or criminal proceedings.

Signing this form is voluntary, but failing to sign it, or revoking it before we receive necessary information, could prevent an accurate or timely decision on your application, and could result in denial. Although the information we obtain with this form is almost never used for any purpose other than those stated above, the information may be disclosed by PEHP's Group Term Life Program without your consent. For example, PEHP's Group Term Life Program may disclose:

1. To enable a third party (e.g., consulting physicians) or other government agency to assist the Group Term Life Program in determining your eligibility for benefits;
2. Pursuant to law authorizing the release of information from PEHP's Group Term Life Program e.g., to Federal or State benefit agencies or auditors;
3. For statistical research and audit activities necessary to assure the integrity and improvement of PEHP's Group Term Life Program. (e.g., to private concerns under contract with PEHP).

Explanations about possible reasons why information you provide us may be used or given out are available upon request from PEHP's Group Term Life Program.

*This general/and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 (“HIPAA”); 45 CFR parts 160 and 164; and State law.*