Pinellas County Schools

Individual Authorization
for Use and/or Disclosure of Protected Health Information

Name of Employee (& SSN): ____

Name of Member: ____

Relationship of Member to Employee: ____

Home Address of Employee: ____

Home Telephone Number: ____

Work Location: ______________________ **Work Telephone Number:** ______________

I hereby authorize the use and/or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I also understand that if the person or organization authorized to receive the information is not a health plan or health care provider, the released information may be redisclosed and may no longer be protected by the federal privacy regulations. ***It is recommended that no PCS employee other than one employed by Risk Management and Employee Benefits assist with claims issues***.

1. Person(s) or organization authorized to disclose the health information:

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2. Person(s) or organization authorized to receive the health information:

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3. Description of health information that may be used/disclosed:

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4. Purpose for which the health information will be used/disclosed *(**Note:** Not required if disclosure is requested by the individual)*:

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5. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to enroll in a health plan, obtain health care treatment or payment or my eligibility for benefits*. *(**Note:** Not required if disclosure is requested by the individual.)*

6. I understand that I may revoke this authorization at any time by providing written notice to the Employee Benefits Privacy Official, Risk Management and Employee Benefits Department, 301 4th St. S.W., Largo, FL 33770. I understand that my revocation will not affect any actions already taken in reliance on this authorization.

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7. I understand I may inspect or copy any information to be used or disclosed under this authorization.

8. Unless otherwise revoked in writing, this authorization will expire _____ (**insert number of days)** days from the date signed below OR upon the occurrence of ______________________________________ ____ **(insert name of event).**

____ ________________________

Signature of Individual (or Legal Representative) Date

____

(Print) Individual's Name

____ ________________________________

(Print) Name of Legal Representative (if applicable) Relationship to Individual

* A health plan may condition enrollment or eligibility for benefits on an individual providing an authorization prior to enrollment if the authorization sought is for the plan's eligibility or enrollment determinations relating to the individual or for its underwriting risk or risk rating determinations and the authorization is not for a use or disclosure of psychotherapy notes. [45 CFR §164.508(b)(4)(ii)(A&B)]

Note: HIPAA "covered entities" (e.g., health plans) must provide a copy of the signed authorization to the individual.