Reset Form

STATE OF DELAWARE

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION FROM THE DELAWAR EMPLOYEE HEALTH CARE PLAN AND DISABILITY INSURANCE PROGRAM

Check One: ☐ **Employee Health Care Plan** ☐ **Disability Insurance Program**

Section 1: **Person whose health information will be disclosed:** *[please print]*

Name:_____

Address:_____

City and State: _____

Health Plan ID # (if applicable): _____

Group # (if applicable): _____

Telephone Number: _____

Birth Date: _____

Section 2: **Person or Entity that has the health information to be released:**

_____ *[please print the name of the entity that has the record to be disclosed; e.g., Health Plan, Dr. Jane Doe, ABC Laboratories, etc.]*

Section 3: **Description of the health information to be released:**

All information related to the claim for medical services or treatment described below.

Claim Number(s):_____ Date(s) of Service: _____

Provider(s) Name: _____

If "information related to a sensitive" diagnosis is to be disclosed, the pertinent boxes must be checked:

☐ **Substance Abuse** ☐ **HIV/AIDS** ☐ **Genetic Testing** ☐ **Mental Health Care**

[*Please note that the types of information to be disclosed by the Plan include: explanation of benefits (EOB) forms, claims history, eligibility determinations, information related to payment of claims or coordination of benefits, medical records obtained and/or reviewed with regard to claims or appeals, and other information that the Plan may have used to make decisions about your eligibility for benefits or the payment of your claims.*]

Section 4: **Person or Entity that will receive the health information:** Representatives of the Statewide Benefits Office and other State Delegates involved in the health and/or disability plan appeal or claim(s) review request.

I authorize the Statewide Benefits Office and other State Delegates to release protected health information to the following person ("Representative"):

Name:_____

Relationship to member: _____

Best contact telephone number: _____

I further authorize the Statewide Benefits Office and other State Delegates to share protected health information with each other and my Representative as necessary for the purpose of my health plan and/or disability program appeal or claim(s) review request. ***A written response will be provided to all members who have submitted a request for a Level II and III STD appeal and for a Level III and Level IV health appeal.***

Your Initials: _____ ***Date:***_____

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Section 5: **Description of the purpose for the release of protected health information:**

☐ At the request of the person whose name appears in *Section 1*

☐ To obtain assistance with adjudication, payment and/or appeal of pending Plan claims

☐ To support a claim for non-health benefits, such as disability benefits, workers compensation benefits or life insurance benefits

☐ Other *[insert description of the purpose]*:_____

Section 6: **Duration of Authorization:** This Authorization will remain effective *[choose an expiration period or event]*:

☐ will expire on_____ *(date)*

☐ for the duration of the review by the Statewide Benefits Office but not greater than one year after date of member's signature

☐ Other *(please specify)*_____

☐ If no date, event or circumstance is included, this Authorization will expire 1-year after date of member signature.

Section 7: **Certification and Acknowledgment:** I certify that I am the person (or the personal representative of the person) designated in Part 1. I agree that my individually identifiable health information described in Part 3 and held by the person or entity listed in Part 2, may be disclosed to the person or entity listed in Part 4 for the purpose(s) designated in Part 5.

I understand that the State of Delaware Employee Health Care Plan and Disability Insurance Program will not condition treatment, payment, enrollment or eligibility on the provision of this Authorization. I understand that I have the right to revoke this Authorization, in writing, at any time, by sending the revocation to the State of Delaware Employee Health Care Plan, Privacy Officer, 97 Commerce Way, Suite 201, Dover, Delaware, 19904, and that the revocation will be effective except to the extent that the Delaware Employee Health Care Plan and Disability Insurance Program has already taken action in reliance on my Authorization. I understand that, once disclosed, it is possible that the health information may be further disclosed by the recipient and no longer subject to protection under applicable federal privacy rules.

By using this form, the parties acknowledge their agreement to conduct transactions by electronic means. A parties electronic signature for purposes of the Uniform Electronic Transactions Act, 6 Del. C. Ch. 12A, may be provided by checking the box as indicated, electronic initials or name, or e-mail confirmation.

I have received a copy of my signed Authorization.

Signature:_____ **Date:** _____

Daytime Telephone:_____ **Email Address**: _____

(If signing as the personal representative of the person in Section 1, print your name and describe your authority to sign for the person and attach any legal documentation which authorizes signature on the member's behalf (power of Attorney, Guardianship, etc.).

Name:_____ Authority: _____

Submit this Completed Form to the Statewide Benefits Office (SBO) by secure email (benefits@delaware.gov), fax (302-739-8339) or by mail (97 Commerce Way, Suite 201, Dover, DE 19904).

For office use:

☐ Authorization fully completed and signed

☐ Copy of Authorization provided to Individual or Personal Representative