SHBP
State Health Benefit Plan
A Division of the Georgia Department of Community Health

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Section A: Participant Information

Instructions: Read and complete the section below. Print clearly.

I understand that my Protected Health Information[1] (or if Personal representative, the Protected Health Information of the Participant) will be released by the State Health Benefit Plan ("SHBP") to the individual(s) in Section C.

Participant Name: _____

Address: _____

Telephone Number: _____ Date of Birth: _____

Identification (ID) Number (from ID card): _____

Second ID Number (if covered under multiple SHBP coverage options): _____

If you are the Personal Representative requesting the information of a Participant, please complete the section below:

Personal Representative Name: _____

Relationship to Participant: _____

Address: _____

Telephone Number: _____ Last Four Digits of SS#: _____

Section B: Protected Health Information To Be Disclosed

Instructions: Read and complete the section below. Print clearly.

Describe the specific health information you are requesting SHBP to disclose (include dates of service, provider name, claim number or other information, as applicable):

_____

_____

Describe the purpose of the information you are requesting SHBP to disclose (if more than one purpose, list each one):

_____

_____

[1] Protected Health Information is defined as any information that identifies you or information in which there is a reasonable basis to believe can be used to identify you and that relates to your past, present, or future physical or mental health or condition, the provision of health care to you, and payment for those services. 45 C.F.R. § 160.103.

Section C: Person(s) Authorized to Receive Protected Health Information

Instructions: Read and complete the section below. Print clearly.

Recipient Name/Title: _____

Company: _____

Address: _____

Telephone Number: _____

Section D: Expiration and Revocation

Instructions: Read and complete the section below. Print clearly.

This authorization will expire (complete only one):

On _____ / _____ / _____
(mm) (dd) (yyyy)

OR

On the occurrence of the event described below, that must relate to the participant or to the purpose of the use and/or disclosure being authorized (for example, upon the termination of coverage under SHBP).
Describe event: _____

Section E: Required Notices

Right to Revoke

You have the right to revoke this authorization at any time, except to the extent that SHBP has acted in reliance upon this authorization, provided that you notify SHBP in writing at the address below:

State Health Benefit Plan
Attention: Dianne Patterson
Post Office Box 1990
Atlanta, GA 30301

-OR-

shbp.eligibility@dch.ga.gov

-OR-

FAX: 1-866-828-4796

Information Subject to Redisclosure

Information disclosed pursuant to this authorization may be subject to redisclosure by the Recipient authorized under Section C, and therefore, will no longer be protected under the HIPAA Privacy Rule.

No Conditions on Treatment, Payment, Enrollment or Eligibility

SHBP does not condition treatment, payment, enrollment or eligibility for benefits on whether the Participant or Personal Representative signs an authorization.

Notice of Privacy Practices

You may view a copy of our Notice of Privacy Practices on the Department of Community Health's website: http://dch.georgia.gov/shbp-legal-notices

Section F: Authorization and Signature

Instructions: Read and complete the section below. Sign and date.

I understand that it is the policy of SHBP not to release such information except for the purpose of treatment, payment, or healthcare operations.

By signing below, I authorize SHBP to discuss and/or disclose my Protected Health Information for the purpose(s) described above to the individual(s) designated in Section C.

If you are the Personal Representative of the Participant, by signing below, you authorize SHBP to discuss and/or disclose the Protected Health Information of the Participant for the purpose(s) described above to the individual(s) designated in Section C.

Signature of Patient or Personal Representative **Date:**

Return the completed Authorization to Release Protected Health Information Form to:

State Health Benefit Plan
Attention: Dianne Patterson
Post Office Box 1990
Atlanta, GA 30301
-OR-

shbp.eligibility@dch.ga.gov

-OR-

FAX: 1-866-828-4796

If you are a Personal Representative requesting the release of Protected Health Information on behalf of a Plan Participant, you must provide documentation sufficient to establish your authority to act on behalf of the person you are representing.

Failure to provide all necessary information will result in a denial of your authorization request.