

EMPLOYEE GROUP INSURANCE

General Authorization for the Use and Disclosure of Protected Health Information

1. By signing this form at the bottom of the page, I hereby authorize Employee Group Insurance (EGI) to obtain, use and disclose certain protected health information from the records of:

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security No.: \_\_\_\_\_

2. The following information may be used and disclosed (specifically identify the records): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. The persons or class of persons who are authorized to receive this information are (either name specific individuals or the type of persons. An example of a class would be "anyone acting on behalf of Dr. X): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

4. The purpose for which the records will be used or disclosed is as follows (check one):

At the request of the individual

Other (specifically identify the purpose): \_\_\_\_\_

\_\_\_\_\_

5. I understand that I may revoke this authorization in writing at any time, except that such revocation will not affect actions already taken in reliance on this authorization and, if applicable, may not be effective as to an insurer's right to contest a claim. I understand that, in order to revoke this authorization, I must send a written notice stating my intent to revoke this authorization to:

ATTN:

Manager of Insurance Benefits/Contact Person

Employee Group Insurance

702 Colorado Street, Suite 6.600

Austin, Texas 78701

(512) 499-4616

6. Unless revoked earlier, this authorization will expire (check one):

On the following date: \_\_\_\_\_

Upon the following event: \_\_\_\_\_

If no expiration date or event is given, it is assumed that the authorization will expire one year after it is signed.

7. I understand that EGI is not conditioning treatment, payment, enrollment in a group health plan, or eligibility for group health plan benefits upon my agreement to sign this authorization.

8. I understand that the information to be used and disclosed pursuant to this authorization form may include sensitive information such as information relating to (1) human immunodeficiency virus ("HIV") infection or acquired immunodeficiency syndrome ("AIDS"), (2) treatment for or history of drug or alcohol abuse, or (3) mental or behavioral health or psychiatric care.

9. I understand that to the extent any recipient of this information, as identified in Paragraph 3 above, is not a "covered entity" under federal privacy law, the information may no longer be protected by federal privacy law once it is disclosed to the recipient and, therefore, may be subject to re-disclosure by the recipient.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If the authorization is signed by a legal representative of the individual:

Printed name of legal representative: \_\_\_\_\_

Representative's authority to act for the individual: \_\_\_\_\_