THE UNIVERSITY OF TEXAS SYSTEM ADMINISTRATION
HIPAA PRIVACY MANUAL

Permission for the Use and/or Disclosure of Protected Health Information to Permit Staff to Conduct Inquiries and Advocacy on Behalf of a Member a Group Health Plan

By signing this form, I hereby authorize The University of Texas System to obtain, use and disclose certain protected health information from the records of:

Name: _____ Daytime Phone # _____

Address: _____

DOB:_____ Benefits ID #* _____ Email address:_____

The following information may be used and disclosed: any information needed to discuss my group health coverage from (specify plan or carrier) _____ as it relates to the following: _____
_____
_____

The persons who are authorized to receive this information are current Office Employee Benefits staff and (specify any other System staff person or from whom you are seeking assistance): _____
_____

The purpose for which the records will be used or disclosed is to allow the authorized persons to help resolve the issue or issues described above.

I understand that I may revoke this permission 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:

Privacy Officer c/o
Systemwide Compliance
The University of Texas System
201 West 7th Street, Suite 300
Austin, Texas 78701

Unless revoked earlier, this permission will expire (check one):

- ☐ On the following date: _____
- ☐ Upon resolution of the issues described in No. 2 above.

I understand that System is not conditioning payment, enrollment in a Group Health Plan, or eligibility for Group Health Plan benefits on my signing this permission form.

I understand that the information to be used and disclosed pursuant to this authorization form may include 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.

* You can look up your UT System Benefits ID number at:
https://utdirect.utexas.edu/nlogon/sgwww/SGPNIBID.WBX

Signature: _____ Date: _____

If the authorization is signed by a Personal Representative of the Individual:

Printed name of Personal Representative: _____

Representative's authority to act for the Individual: _____

If signed by a Personal Representative of the Individual, please note that we must verify that you are this Individual's legal representative for purposes of filing this Authorization. Please enclose any documents that support this authority (Power of Attorney, Court Order, etc). As this person's representative, can you be contacted at the address, e-mail or phone number listed above? If not, please provide your mailing address, e-mail address and phone number:

For System Use Only

Person processing request: _____

Date request received: _____

Action taken: _____

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