# CITY OF ST. LOUIS

## GROUP HEALTH PLAN

## AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Individual's Name ____________________________________________________________

Individual's Date of Birth ____________________  Individual's SS#____________________
*(optional and last 4 digits only)*

____________________________________________________________ hereby authorize
(*Individual or Personal Representative*)

_____________________________________________to disclose specific health information
*(Group Health Plan)*

from the records of the above-named Individual to the following employee(s) of the City of St. Louis Department of Personnel (as Plan Sponsor of the Group Health Plan):

__________________________________________________________________________,
*(Name(s) of City of St. Louis Personnel Department employee)*

City of St. Louis Department of Personnel
1114 Market Street, Room 700
St. Louis, MO  63101-2009

referred to hereinafter as the Recipient(s) for the following specific purpose(s):

__________________________________________________________________________

__________________________________________________________________________

The specific information to be disclosed is as follows: ________________________________

__________________________________________________________________________

__________________________________________________________________________

This authorization includes oral information that may be disclosed by the Group Health Plan to the above-named Recipient(s) for the foretasted purpose(s).

I understand that I may revoke this authorization at any time. If I want to revoke this authorization, I have to do so in writing and send it to above specified Recipient(s) authorized to receive the health information and/or to the persons who are authorized to disclose the health information under this authorization form. My revocation of this authorization, though, will not apply to any information that has already been disclosed before I've effectively revoked this authorization. Also, my revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date or event: ______________________________.
If I fail to specify an expiration date or event, this authorization will expire in six (6) months.

I understand that any information disclosed under this authorization to the Recipient(s) might not be protected by state or federal confidentiality or privacy laws or rules and could be re-disclosed

by the Recipient(s).

I understand that if my record contains information relating to HIV infections, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, or behavioral or mental health services, this disclosure will include that information.

I also understand that I may refuse to sign this authorization. My refusal to sign an authorization will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if treatment is research-related, treatment may be denied if authorization to a health care provider of such treatment is not given.

NOTE: If you are signing on behalf of an Individual for whom you are the personal representative, you must attach a copy of your appointment as personal representative. If you are signing otherwise on behalf of the patient, state the basis for your authority to request the records of the Individual.

A photo static copy of this authorization may be used in place of an original.

I have received a copy of my signed authorization.

_______________________________________________ _______________________________
*(Signature of Individual or Personal Representative)* *(Date)*

_______________________________________________ _______________________________
*(Print name of Individual or Personal Representative)* *(Relationship to Individual)*

_______________________________________________
*(Individual's address of record)*

_______________________________________________
*(Individual's telephone number)*

_______________________________________________
*(individual's email address)*

Department of Personnel (Plan Sponsor for Group Health Plan: 9/26/2012: Authorization Form