GEHA.

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO A THIRD PARTY

This form is for members and dependents covered by GEHA health plans (FEHB/FEDVIP).

NOTE: PLEASE COMPLETE ALL PARTS OF THIS FORM. INCOMPLETE FORMS MAY BE RETURNED.

PART A - MEMBER INFORMATION

Subscriber Name: _____ **Subscriber ID Number:** _____

Address: _____

Telephone Number: _____ **Patient Name:** _____ **Date of Birth:** _____

PART B - PERSON OR COMPANY WHO WILL RECEIVE THIS INFORMATION

I authorize my health plan, **Government Employees Health Association, Inc. (GEHA)**, to disclose my individually identifiable health records to the following third party as described below:

Name: RECORDS DEPOSITION SERVICE, INC.

Address: PO BOX 5054, SOUTHFIELD, MI, 48086-5054

PART C - INFORMATION TO BE RELEASED

I authorize GEHA to disclose claims and medical information in its files as follows:

_____ Limit disclosure to all healthcare information, **EXCLUDING** any mental health, drug/alcohol abuse, or communicable disease treatment records that may be maintained by GEHA.

_____ Limit disclosure to Benefit / Coverage information.

_____ Limit disclosure to healthcare services provided between the dates: ___/___/___ to ___/___/___

_____ All healthcare information including any mental health, drug/alcohol abuse, or communicable disease treatment records that may be maintained by GEHA.

X Other (specify) PLEASE SEE ATTACHED SUBPOENA OR LETTER REQUEST

PART D - PURPOSE OF THE DISCLOSURE

_____ Request of the individual/personal representative

X Other (Please specify): PRE TRIAL DISCOVERY

PART E - I UNDERSTAND AND AGREE:

- This authorization is voluntary and will automatically expire upon disclosure of the requested records.
- I may revoke this authorization at any time by notifying GEHA in writing to the address provided on this form.
- I further understand if I do revoke the authorization, it will not have any affect on any actions taken before GEHA received the revocation.
- If the person I have authorized is not subject to federal privacy laws, my protected health information may no longer be protected by those privacy laws, and the person I have authorized may further disclose my protected health information without my authorization.
- My health information may contain information created by other person or entities including health care providers and may contain medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information.
- By signing this form, I understand and agree that GEHA and GEHA business associates may disclose my protected health information as outlined to the person(s) named for the purpose(s) described above.
- I have had full opportunity to read and consider the content of this Authorization Form.
- GEHA will not condition treatment, payment, enrollment, or eligibility for benefits based on your signature on this form.

Date: _____ Patient or Legal Representative's Signature: _____

Relationship to patient: _____
(i.e. parent, legal guardian, power of attorney, etc.)

NOTE: If the signature is not that of the patient or the parent when the child is a minor, appropriate legal documentation is required to accept the signature.

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION FORM AFTER YOU SIGN IT.
PLEASE RETAIN A COPY FOR YOUR RECORDS AND RETURN THE ORIGINAL SIGNED AUTHORIZATION FORM TO:

GEHA
ATTN: Authorization Department
P.O. Box 438
Independence, MO 64051-0438
FAX : (816) 434-4477 ATTN: INC-7007