THE GEORGE WASHINGTON UNIVERSITY

WASHINGTON, DC

THE GEORGE WASHINGTON UNIVERSITY GROUP HEALTH PLAN'S AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of the protected health information (PHI) described in this authorization.

Employee Name:_____

GWID: _____

Name of Person Receiving Services (if other than employee): _____

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1. Person/organization/group of persons authorized to provide the information or source of information:

   - ☐ Medical Insurance Provider
   - ☐ Prescription Benefit Provider
   - ☐ Dental Plan Provider
   - ☐ Vision Plan Provider
   - ☐ Flexible Spending Account Provider (Dependent Care, Health Care)
   - ☐ The George Washington University Benefits Administration Department
   - ☐ Other (*please specify)* _____

2. Person/organization/group of persons authorized to receive and use the information:

   - ☐ The George Washington University Benefits Administration Department
   - ☐ Other *(please specify)* _____

3. Please check below if you want the information sent to:

   - ☐ The George Washington University Benefits Administration Department
   - ☐ Other *(provide detailed information)* _____

4. The records to be disclosed cover the following period(s):

   From (Date): _____To (Date): _____

   From (Date): _____To (Date): _____

5. Information to be disclosed (please check only that which applies):

   - ☐ Inquire into the status of a claim
   - ☐ Provide me assistance in understanding my health plan
   - ☐ Other (provide detail below)

   _____

   _____

6. Right to revoke:

   I understand that I have the right to revoke this authorization at any time by submitting my revocation in writing to the Director of Benefits Administration.

   A revocation of this authorization is effective after it is received and recorded by the Director of Benefit Administration. Any use or disclosure made prior to the recording of the revocation by the Benefit Administration Director of this authorization will not be affected by a revocation.

7. Redisclosure of health information provided pursuant to authorization:

   I understand that after this information is disclosed, federal law might not protect it and the recipient may be authorized to redisclose it.

8. Copies:

   The Benefits Administration Department will provide a copy of this authorization to me. At my request, the Benefits Administration Department may provide an additional copy to me or allow me to inspect a copy of the authorization kept in their records.

9. Expiration of Authorization:

   I understand that this authorization will expire when my employment with The George Washington University terminates or when my receipt of benefits from GW terminates, or earlier, if indicated below:

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Signature of Employee:_____ Date: _____

PERSONAL REPRESENTATIVE (if applicable):

NOTE:

I certify that I have the authority to sign this form on the basis of_____ (e.g., healthcare power of attorney, etc.). I understand that I must provide a copy of any form or document that is the basis of this authority at the request of the Benefits Administration Department.

Signature of Personal Representative: _____

Printed Name of Personal Representative: _____

Date: _____

_____

Return to:

benefits@gwu.edu or Fax: 703-726-8385
Benefits Administration Department
45155 Research Place, Suite 160
Ashburn, VA 20147

For Plan Use Only:

Date Request Received _____

Received By: _____