

EMPLOYEE GROUP INSURANCE

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

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: any information needed to discuss my group health coverage from (specify plan or carrier) _____ as it relates to the following: _____

3. The persons who are authorized to receive this information are current EGI Benefits staff and (specify the staff person or from whom you are seeking assistance) _____

4. 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 in No. 2 above.

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 resolution of the issues described in No. 2 above:

7. I understand that EGI is not conditioning treatment, payment, enrollment in a Group Health Plan, or eligibility for Group Health Plan benefits on my signing this authorization.

8. 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.

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: _____

If signed by a legal 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 below:

