COLORADO PERA

# Authorization to Use and/or Disclose Protected Health Information (PHI)

Colorado Public Employees' Retirement Association
PO Box 5800, Denver, Colorado 80217-5800
1-800-759-PERA (7372) • Fax: 303-863-3727 • www.copera.org

This form allows Colorado PERA to release your personal health information, on file with PERA, as it pertains to your participation in PERA's health plan to specific individuals/entities. Completing this form does not authorize release of information other than that specifically described below.

**Member/ Retiree SSN** ☐☐☐ ☐☐ ☐☐☐☐

## PERA Member/ Retiree

Name _____
Last First MI

Date of Birth _____ Telephone Number (_____) _____
Month/Day/Year

Email Address _____

Sign up for electronic delivery of PERA information? ❑ Yes ❑ No

**Name of person whose health information is the subject of this *Authorization:***

Name _____
Last First MI

Relationship to member/retiree: ❑ Self ❑ Other (specify) _____

## Release To

Entity (company or organization) or individual to whom information is to be released. If more than one entity, please use separate forms.

Name _____
Entity or Individual

Address _____
Street City State ZIP Code

Telephone Number (_____) _____

Purpose for which information will be used or disclosed:

❑ To facilitate the resolution of a claim dispute
❑ At my request
❑ Other (specify) _____

## Authorization of Specific Information

I authorize PERA and PERA's health care plan to use and/or disclose the health information described below. Specify the health information to be released and/or used, including (if applicable) the time period(s) to which the information relates.

Select only one of the following boxes:

❑ All of my past, present, or future health claims and/or medical records or other health information
❑ All of my health information relating to _____
❑ Other (specify) _____

Without my express revocation, this consent will automatically expire one (1) year from the date hereof, but in any event:

❑ 180 days from the date hereof; or
❑ On the following date _____; or
❑ Upon my disenrollment from PERA's health plan; or
❑ Other (specify) _____

*(Continued on reverse)*

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## Authorization to Use and/or Disclose Protected Health Information (PHI) (continued)

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### Your Rights Concerning This *Authorization*

If you decline to sign this authorization, PERA may be limited in its use or disclosure of certain information. Apart from the effect of that limitation, your decision not to sign will not affect your eligibility or enrollment for coverage or the payment of health benefits.

You can revoke this *Authorization* at any time by submitting a written revocation to PERA, PO Box 5800, Denver, CO 80217-5800.

A revocation will not apply to information that has already been used or disclosed in reliance on the *Authorization.* Once the information is disclosed pursuant to this *Authorization,* it may be redisclosed by the recipient and the information may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA).

### Certification

I certify that this *Authorization* has been made voluntarily and that the information given on this form is accurate to the best of my knowledge.

***Sign Here*** ➔ **Signature of Member/Retiree**_____ **Date** _____

If you are not the member/retiree but are signing this form because you are the guardian, have power of attorney, etc., for the person whose medical information is being released, please explain your authority to act on his/her behalf, include a copy of your power of attorney or other authorization, and sign below. (If you have already provided this authorization to PERA, you do not need to send another copy.)

_____

**Signature** _____ **Date** _____