EXCHANGE

HIPAA COMPLIANT AUTHORIZATION
FOR
RELEASE OF PERSONAL HEALTH INFORMATION/EMPLOYMENT INFORMATION

Privacy Act of 1974: Solicitation of your Social Security Number and/or other personal information is authorized by Title 10, U.S. Code 3013 and 8013. Failure to provide requested information could result in not locating the authorized responsive documentation/records.
Instructions: Please complete all blank areas and sign. When complete the form should be returned to the address listed.

Pursuant to the Privacy Act, 5 U.S.C. §552a and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I hereby voluntarily authorize the Army and Air Force Exchange Service (hereinafter "the Exchange") or their Third Party Administrator (TPA) to use or disclose my Employment and Personal Health Information (PHI) to the following for the purpose of

_____

Disclose to
Name/Organization/Representative: _____

Street Address: _____ Phone: _____

City: _____ State: _____ ZIP: _____ E-mail _____

Disclosure is authorized for the following PHI relative to my work-related/occupational injury or illness/workers' compensation claim number(s)[if known]

_____ :

All portions, regardless of confidentiality of my files and records held by the Exchange to include but not limited to the Department of Labor (DOL) reports; billing records showing charges, expenses, costs and payments, including payments received, hospital bills, bills for services and other relative and material information; ; X-Rays; interpretation of x-rays or other tests (including a copy of the report); drug and alcohol abuse testing, evaluation and treatment; mental health information consisting of but not limited to notes, records, reports of psychotherapy diagnosis evaluation and treatment including the diagnosis and prognosis; physical therapy records; outpatient records; mental illness, counseling referrals and/or a history of testing or treatment of human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS) and sexually transmitted diseases and conditions ; vital statistics, medical examination report and conclusions; clinical notes, nurses' notes, patient history of injury, medical provider's notes and evaluations; test results, subjective and objective complaints; hospital operational logs, emergency logs, tissues committee reports, correspondence. This authorization also includes all employment data, payroll data and documents held by the Exchange relative to benefits,

Other (Specify): _____

Conditions
I understand that I have the right to revoke this authorization at any time by notifying the Exchange in writing at the address below. I understand that the revocation is only effective after it is received and does not apply to disclosures which have already occurred. If this authorization is not revoked it shall automatically terminate one year from the date of signature below. I understand that the disclosure of my specific personal health information may include data regarding drug or alcohol use, counseling referrals and/or a history of testing or treatment of acquired immune deficiency syndrome (AIDS) or related conditions. I understand that after the above approved disclosure is made to the recipient, federal law might not protect it from being re-disclosed. Routine Use Disclosure may apply. Any further disclosure will be compliant with DoD 6025.18-R, Section C7.12 (January 2003).

This form must be mailed to the following address:
Army and Air Force Exchange Service
Office of the General Counsel
Attn: Compliance Division
3911 South Walton Walker Blvd.
Dallas, TX 75236-1598

PERSONAL IDENTIFIER FOR LOCATION OF RESPONSIVE DOCUMENTS/RECORDS AS AUTHORIZED ABOVE

Last Four Numbers of Social Security Number and/or Birthdate: _____

_____ _____ _____
PRINTED NAME SIGNATURE DATE

Sworn to and subscribed before me this _____ day of _____, _____. (SEAL)

_____ _____
Notary Signature Commission Expiration Date

PERSONAL REPRESENTATIVE SECTION:

If a personal representative executes this form, the representative warrants that he or she has authorization to sign on the basis of (List of basis for representation; i.e. parent or guardian of minor): _____

Sworn to and subscribed before me this _____ day of _____, _____. (SEAL)

_____ _____
Notary Signature Commission Expiration Date