HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Privacy Act of 1974: Title 10, U.S. Code 7013, 9013, and U.S Presidential Executive Order 9397 (SSN) authorizes the solicitation of your Social Security Number and/or other personal information. 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, returned to the Army and Air Force Exchange Service by one of the means listed below. Do not use this form to request employment or payroll records.

- Pursuant to 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 Protected Health Information (PHI) to the following for the purpose of
____

Disclose to

Name/Organization/Representative: ____

Street Address: ______________________________ Phone: ______________________

City: ____________________ State: ________ ZIP: ____________ E-mail ____________________

- This disclosure authorizes the release of the following PHI relative to my injury/illness or work-related/occupational injury or illness. (Please list any workers' compensation claim number(s) [if known]:

____ :

All portions, regardless of confidentiality, of my PHI files and records held by the Exchange including but not limited to the Department of Labor (DOL) reports and AETNA and Third Party Administrator's sensitive information maintained within the administrative record, medical and consultant notes. This includes any and all 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, and correspondence. This authorization also includes documents held by the Exchange relative to health and dental claims.

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 the Exchange receives the revocation and does not apply to disclosures, which have already occurred. If not revoked, this authorization 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 disclosure is made to the above recipient, federal law might not protect it from being re-disclosed. Routine Use Disclosure may apply. Any further disclosures will be compliant with DoD 6025.18-R, Section C7.12 (January 2003).

When completed and notarized, please return by one of the following means. You must submit your request for information/documents along with this form.

Mail:

Army and Air Force Exchange Service
Office of the General Counsel
Compliance Division
3911 South Walton Walker Blvd.
Dallas, TX 75236-1598

e-mail:
PrivacyManager@aafes.com

FAX:
214-465-2912

- **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

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