THE UNIVERSITY OF VIRGINIA HEALTH PLAN/
HEALTH CARE REIMBURSEMENT ACCOUNT PLAN FOR EMPLOYEES OF THE UNIVERSITY OF VIRGINIA

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO FAMILY MEMBER OR OTHER PERSON

Explanation of this Form: The Health Insurance Portability and Accountability Act ("HIPAA") privacy regulations became effective on April 14, 2003. The privacy regulations generally require, among other things, that the University of Virginia Health Plan and the Health Care Reimbursement Account Plan for Employees of the University of Virginia (the health care component of the Flexible Spending Account Plan) (jointly called the "Plan") only disclose Protected Health Information ("PHI") to the individual who is the subject of that information or pursuant to an authorization from that individual. PHI is defined by HIPAA, but generally includes any personal health information. For example, except in certain circumstances, the Plan may not disclose a participant's PHI to a spouse, or an adult dependent's PHI to the participant or spouse, or the spouse's PHI to the participant. (Generally, a minor child's PHI may be disclosed to either parent or legal guardian without an authorization). Any adult individual, however, may authorize that his or her PHI may be disclosed to family members or others. You may do so by completing the following Authorization. Or, you may complete an Authorization each time that you want specific PHI disclosed to a family member or another person. You can also choose not to authorize the Plan to share your PHI with any family members or other persons.

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1. My name is_____, and my Date of Birth or UVA ID Number is _____. If I am a dependent, the participant through whom I am covered by the Plan is _____ with Aetna ID number_____. I hereby authorize my PHI to be disclosed as described in this Authorization.

2. I authorize the Plan to release PHI about me to my family members or others identified in ¶ 5 that relates to my health claims and eligibility records. This information may be oral or written information, and includes information such as claims detail, claims status reports, payment records, Explanation of Benefits forms, and Coordination of Benefits information.

3. This PHI is to be used by my family members or others identified in ¶ 5 for the purposes of assisting me in obtaining necessary medical care, filing health care claims on my behalf, checking on the status of health care claims that have been filed on my behalf, and working with the Plan to work out any other issues that may arise with respect to the health benefits that are provided to me by the Plan.

4. I also request that the following limitations be placed on the disclosure of my PHI to my family members or others identified in ¶ 5: (*This section should only be filled out if you wish to limit the disclosures of your PHI to your family members or others identified in ¶ 5.*)

_____

_____.

5. I authorize my above-described PHI to be disclosed only to the following identified individuals: (*There is no limit to the number of individuals you can list in this section.*)

Name and Date of Birth or UVa ID Number	Describe Relationship (*i.e., husband, wife, parent, friend*)
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6. I understand that the Plan may not condition my treatment, payment, enrollment, or eligibility for benefits on whether I agree to sign this Authorization.

7. I understand that once my PHI is disclosed pursuant to this Authorization, the federal privacy protections will no longer apply to the disclosed PHI, and thus, my family member(s) and others described in ¶ 5 to whom my PHI is disclosed may re-disclose that PHI.

8. I understand that I have the right to revoke this Authorization at any time by sending a letter or e-mail to:

UVA Health Plan Privacy Officer
914 Emmet Street
P.O. Box 400127
Charlottesville, VA 22904-4127

I understand that the revocation will take effect on the date that it is received by the Privacy Officer. However, I understand that any revocation will be effective only to the extent that the Plan has not already disclosed my PHI based on this Authorization.

9. This Authorization will expire at the end of my enrollment in the Plan or, if earlier, on the following date or event: _____
_____.

_____
Printed Name (of person giving authorization)

_____ _____
Signature of person giving authorization Date

_____
Name of personal representative (if applicable)

_____ _____
Signature of personal representative (if applicable) Date

_____.
Description of personal representative's authority to act for the individual (if applicable)

Please return the completed form to the Benefits Office in UVA Human Resources at 914 Emmet Street, P.O. Box 400127, Charlottesville, VA 22904-4127.