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

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Explanation of this Form: The Health Insurance Portability and Accountability Act ("HIPAA") privacy regulations become 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. You may use this Authorization if you want specific PHI to be disclosed to another person or entity.

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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. The information to be disclosed is: _____

_____

_____

3. The Plan may disclose the above-described information to: (*Include name or classification of persons to whom the PHI may be disclosed.*) _____

_____

4. This disclosure is made for the following purposes: (*Please list each purpose for the requested disclosure. If the disclosure is at your request, you may state "At my request."*)

_____

5. I understand that the Plan may not condition my treatment, payment, enrollment, or eligibility for benefits on whether I agree to sign this Authorization.

6. I understand that once my PHI is disclosed pursuant to this Authorization, the federal privacy protection will no longer apply to the disclosed PHI, and thus, the persons or entities described in ¶ 3 to whom my PHI is disclosed may re-disclose that PHI.

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

Rebecca Gristina, UVA Health Plan Privacy Officer
2420 Old Ivy Road
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 health information based on this Authorization.

8. This Authorization shall expire on the following date or event: _____.

HIPAA does not impose any specific time limit on authorizations. For example, an authorization could state that it is good for 30 days, 90 days or even for 2 years. An authorization could also provide that it expires when the person giving the authorization reaches a certain age.

_____
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
UVA Human Resources Benefits Division at 2420 Old Ivy Rd, P.O. Box 400127, Charlottesville, VA 22904-4127 or by fax at (434) 924-4486.