

Mailing Address:  
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Colorado Springs, CO  
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**Covered Person or Covered Person's  
Dependent Authorization for  
Disclosure of Health Information**  
*(Applicable to Self-Funded Customers)*

**This authorization complies with the HIPAA Privacy Rule and permits health care providers  
and other covered entities to disclose health information**

1. I initiate this authorization for disclosure of my health information (defined in #2). I authorize my Group Health Plan, its agents, and business associates to disclose my health information as described below: *Statement required by §164.508(c)(1)(ii).*

a) Please disclose my health information to (check as applicable):

My employer/plan sponsor (Please include name and address of person or entity to whom the information described below is to be disclosed): *Statement required by §164.508(c)(1)(iii).*

Employer: \_\_\_\_\_

Attn: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Another person or entity (Please include name and address of person or entity to whom the information is to be disclosed): *Statement required by §164.508(c)(1)(iii).*

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

b) Describe the health information to be disclosed (check as applicable): *Statement required by §164.508(c)(1)(i).*

Please disclose any and all health information requested by the person or entity described above.

Please disclose my health information necessary for the person or entity described above to act as a claim advocate:

\_\_\_\_\_

Other (please describe):

\_\_\_\_\_

c) Reason for the disclosure (optional): *Statement required by 164.508(c)(1)(iv).*

\_\_\_\_\_

By my signature, I acknowledge that any prior agreements I have made to restrict my health information do not apply to the information released under to this authorization.

2. I understand my health information may be used or disclosed as set forth by this authorization. Protected health information includes information created or received by my Group Health Plan and its agents and business associates. Protected health information also includes but is not limited to: hospital records, treatment records/notes, alcohol or drug abuse treatment, consultation reports, workers' compensation information, diagnosis, prescriptions, test results, vocational testing/counseling information, and benefit information. *Statement required by §164.508(c)(1)(i).*

3. If you are the representative of the person whose information is to be shared (including a parent acting as a representative on a child's behalf) describe the scope of your authority to act on the person's behalf: *Statement required by §164.508(c)(1)(vi).*

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4. I understand that any information disclosed under this authorization may no longer be covered by the privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and may be subject to redisclosure. *Statement required by §164.508(c)(2)(iii).* I understand that any health information received by my employer under this authorization will be kept strictly confidential and will be segregated from records relating to my employment. It will be used solely for the purpose for which the disclosure was authorized.

5. I understand that I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization, if the request for revocation is in writing and sent to: Health Information Protection Analyst, Group Compliance, Principal Life Insurance Company, 711 High, Des Moines, IA. 50392-0002. To request a revocation form contact the Health Information Protection Analyst. *Statement required by §164.508(c)(2)(i).* Such revocation shall not apply to any use or disclosure of my Protected Health Information specifically allowed without authorization by HIPAA and no action relating to this authorization shall be construed as creating any restriction on the uses and disclosures that HIPAA allows without my authorization.

6. This authorization will be valid (check as applicable):

For the term of the medical, dental, and/or vision coverages I am enrolled in and any renewal of those coverages unless state or federal law requires a shorter expiration period.

For as long as necessary to bring the specific claim or situation described above to a conclusion. *Statement required by §164.508 (c)(1)(v).*

7. I understand that I am not required to sign this authorization form and that my Group Health Plan will not condition the provision of payment of a claim for medical, dental, or vision coverages on the signing of this authorization. *Statement required by §164.508(c)(2)(ii).*

I initiate this authorization for disclosure of health information. I have read and I understand this authorization. Upon receipt of your signed authorization, a copy will be provided to you. *Statement required by §164.508(c)(4).* A photocopy of this authorization shall be considered as effective and valid as the original. No alteration of this form will be accepted.

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**Name of person whose information is to be shared** **Date of birth** **I.D. number**

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**Address of person whose information is to be shared** **Phone number**

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**Employer name** **Account number**

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**Employer address**

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**Name of personal or legal representative (if applicable)**

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**Relationship of personal or legal representative to person whose information is to be shared**

If signing on behalf of another, include proper documentation that attests to your ability to sign (Court-stamped Letters of Appointment as Executor of Estate, proof of custody, power of attorney, etc.). *Statement required by §164.508(c)(1)(vi).*

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**Signature of person whose information is to be shared** **Date**  
(or person's representative) *Statement required by §164.508(c)(1)(vi).*