SCHOOL EMPLOYEES LOSS FUND (SELF)

HIPAA Privacy Authorization

For Disclosure of Protected Health Information
Relevant to Pending Claims

Patient's Name: _____

Address: _____ Date of Birth: _____

1. I make this Authorization for the purpose of copying records in connection with a claim to which I am a party.
2. This Authorization is directed to and applies to protected health information maintained by:
(Hospital, Physician, Medical Provider, etc.)

_____

_____

_____

_____

3. I hereby authorize the above, its director, administrative and clinical staff or assignees, medical information services and billing departments to release any and all medical records and information from my date of birth to the present unless specified otherwise, relating to my care and treatment including x-rays, photographs, electronic and digital files and any other records, unless I expressly direct or specify otherwise. I understand that medical information may include records, if any, relating to treatment for alcohol and drug abuse protected under the regulations in 42 C.F.R. Part 2, psychiatric/psychological services and social work records and any information regarding communicable diseases and infections, tuberculosis, venereal diseases, sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) or ARC.
4. This information is to be released for copying purposes to: _____
_____ or their agent, _____
5. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by the Federal Privacy Rules.
6. This authorization shall be in force and in effect until the conclusion of the pending claim unless otherwise specified.
7. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and send it to the hospital, doctor or other custodian of medical information. I understand that the revocation will not apply to information that has already been released in response to this authorization.
8. I understand that authorizing the release of this health information is voluntary and that I need not sign this form in order to ensure health care treatment, eligibility for benefits, payment or health plan enrollment.
9. A copy of this authorization is as valid as the original.

All Pertinent Sections Of This Form Must Be Completed Before Signing

	X
Date	Signature of Patient or Personal Representative
Description of Personal Representative's Authority or Relationship	Print Name of Patient or Personal Representative