

**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 Southern Health 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:

Joanne R. Hayden, 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 health information based on this Authorization.

8. This Authorization shall expire 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)