

Authorization For Disclosure of Protected Health Information (PHI)

This authorization complies with the HIPAA Privacy Rule GuideStone Financial Resources of the Southern Baptist Convention

Please print.

HEALTH PLAN PARTICIPANT INFORMATION

Name: _____ Social Security number: _____

INDIVIDUAL WHOSE PHI WILL BE DISCLOSED

Name: _____ Social Security number: _____

Address: _____ Telephone number: (_____) _____

1. I, _____, initiate this authorization for disclosure of my Protected Health Information. I authorize my Health Plan, its agents, and business associates to disclose my Protected Health Information as described below. [Statement required by §164.508(c)(1)(ii)]

a) Disclose my Protected Health Information to:

Name and address of person or entity to whom we will disclose the information described below. [Statement required by §164.508(c)(1)(iii)]

b) Describe the Protected Health Information to be disclosed (check as applicable): [Statement required by §164.508(c)(1)(i)]

- Disclose any and all of my Protected Health Information requested by the person or entity described above.
 Disclose only the portion of my Protected Health Information necessary for the person or entity designated above to act as a claim advocate on my behalf for the following situation:

Other (please describe):

c) Reason for the disclosure (a reason is not required): [Statement required by 164.508(c)(1)(iv)]

2. I understand my Protected Health Information may be used or disclosed as set forth by this authorization. Protected Health Information includes information created or received by my Health Plan, its agents and business associates. Protected Health Information also includes, but is not limited to: [Statement required by §164.508(c)(1)(i)]

- Hospital records
- Treatment records/office notes (including information about sexually transmitted diseases, cancer or genetic conditions)
- Consultation reports
- Alcohol or substance abuse treatment records
- Worker's compensation information
- Diagnosis
- Prescriptions
- Test results
- Vocational testing/counseling information
- Benefit information



3. I understand that any information disclosed pursuant to 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 re-disclosure by the person or entity to whom it was disclosed. [Statement required by §164.508(c)(2)(iii)]

4. I understand that I may revoke this authorization at any time by sending written notification to:

HIPAA Privacy Contact
GuideStone Financial Resources, SBC
2401 Cedar Springs Road
Dallas, TX 75201-1498
hipaaprivacycontact@GuideStone.org

To obtain a *Withdrawal of Authorization for PHI Disclosure* form, visit GuideStone's Web site, www.GuideStone.org, or call 1-800-262-0511 for assistance from a Customer Relations specialist. [Statement required by §164.508(c)(2)(i)]

Important note: A revocation is not effective to the extent the parties named in this authorization have relied on the use or disclosure of the Protected Health Information. Such revocation shall not apply to any use or disclosure of 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 authorization.

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

- 24 months following the date of my signature below.
- As long as necessary to bring the specific claim or situation described above to a conclusion or 24 months following the date of my signature below, whichever occurs first. [Statement required by §164.508 (c)(1)(v)]

6. I understand that I am not required to sign this authorization form and that my Health Plan will not condition the provision of payment of a medical claim on the signing of this authorization. [Statement required by §164.508(c)(2)(ii)]

I initiate this authorization for disclosure of Protected Health Information. I have read and understood this authorization. I know that I may request and receive a copy of it. [Statement required by §164.508(c)(4)] By signing this authorization, I acknowledge that any agreements I have made to restrict my Protected Health Information do not apply to the information released pursuant to this authorization. A photocopy of this authorization shall be considered as effective and valid as the original. No alteration of this form will be accepted.

INFORMATION ABOUT THE INDIVIDUAL'S PERSONAL OR LEGAL REPRESENTATIVE, IF APPLICABLE

Name: _____ Relationship: _____

If signing on behalf of another, please include the proper documentation that attests to your ability to sign (death certificate, court-stamped Letters of Appointment of the Executor of Estate, proof of custody, power of attorney, etc.). [Statement required by §164.508(c)(1)(vi)]

SIGNATURE OF INDIVIDUAL, COVERED DEPENDENT OR REPRESENTATIVE [STATEMENT REQUIRED BY §164.508(C)(1)(VI)]

Name: _____ Date: ____/____/____

Return form to:

GuideStone Financial Resources, SBC
2401 Cedar Springs Road
Dallas, TX 75201-1498
Fax: 214-720-2105