Health Plan

Authorization to Release Medical Information

I hereby authorize the use or disclosure of my medical information as described below. **(Please print clearly)**
OSU Employee/Member Information:

Name____ Date of birth ___/___/_____

Address____

City ________________________ State ___________________ ZIP Code______________________

Phone__________________________ E-mail_________________________________

OSU Employee ID # __________________ NGS Subscriber Number _________________________

I authorize the release of medical information to:

Name____

Relationship to the Employee/Member _____________________ Phone______________________

Address____

City ________________________ State ___________________ ZIP Code______________________

I authorize: (Please select all that apply)

___OSU Health Plan _____Delta Dental ______NGS-Medical _____VSP-Vision ____ Express Scripts-Prescription

______Global Care ____ Other (please specify)____

Purpose of disclosure (please give specific information)

____

____

Specific information to be disclosed (include date of service, related diagnosis or other description)

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This authorization will expire: (Please select one)

____ 60 days after it is signed ____ Upon my disenrollment from the OSU Health Plan

____Other (please give specific date or event) ____

I understand that if the person or entity who receives the above information is not a health care provider or health plan covered by federal privacy regulations such as HIPAA, the information described above may be re-disclosed by such person or entity and may no longer be protected by federal privacy regulations.

I understand that I may revoke this authorization at any time by sending a written revocation to the entity I have checked above, and once processed, no further information will be disclosed under this authorization.

I understand that I am not obligated to sign this authorization form, that I do so voluntarily, and that payment will not be conditioned on my signing. However, I also understand that enrollment in a health plan or eligibility for benefits may be conditioned on provision of this authorization, if it is for a health plan's eligibility or enrollment determination relating to me, or for its underwriting or risk rating determinations.

____ _____________________
Signature of Member, Person Authorized to Consent or Wellness Representative **Date Signed**

For this authorization form to be valid, it must be filled out completely. Return this form to the Compliance and Quality Improvement Manager, OSU Health Plan, Inc., 700 Ackerman Road, Suite 440, Columbus, Ohio 43202 or fax to (614) 292-2667.