ORU

HIPAA Authorization Form

Name: _____

Address: _____

For purposes of this Form, the term "Plan" means all insured and uninsured benefit-programs offered by ORU to its employees and/or their eligible dependents as defined in the Oral Roberts University Group Benefit Plan Summary.

1. ***Check one of the following:***

- ❑ I am a covered employee under the Plan
- ❑ I am covered under the Plan as a spouse or dependent of: _____
  (print name of covered employee)
- ❑ Other (describe): _____

2. **I hereby authorize the use or disclosure of my protected health information ("PHI") as follows *(complete Items a through e)*:**

a. *Specific Benefit Programs(s) (including applicable insurers or claim administrators) authorization applies to:*

- ❑ All Plan Benefit Programs
- ❑ Only Plan Benefit Programs Listed: _____

b. *Specific person (or class of persons) authorized to receive and use the information:*

- ❑ My spouse, whose name is: _____
- ❑ My parents, whose names are: _____
- ❑ Other (name and relationship): _____

c. *Specific description of the information to be used or disclosed:*

- ❑ All information held by or on behalf of the Plan
- ❑ All information relating to the following illness or injury: _____
- ❑ Other (describe): _____

d. *Purpose(s) of the request:*

- ❑ To assist me with any matter relating to my Plan coverage
- ❑ Other (describe): _____

e. *This authorization will expire on:*

- ❑ When my coverage under the Plan terminates
- ❑ Other date or event (describe in relation to the individual or purpose): _____

3. **My Rights***:* I understand that I have the right to revoke this authorization at any time by notifying the Plan's Privacy Officer, in writing at C/O Risk Management, Oral Roberts University, 7777 S. Lewis, Tulsa, OK 74171 . I understand that any use or disclosure made prior to the Privacy Officer's receipt of a revocation under this authorization and the Privacy Officer's communication of such revocation to the applicable insurer or claim administrator will not be affected by such revocation. I understand that after this information is disclosed, Federal law might not protect it and the recipient might re-disclose the information without my authorization. I understand that I am entitled to receive a copy of this authorization. I understand that I am not required to sign this authorization in order to receive health or dental care benefits (payment, treatment, eligibility or enrollment).

I understand that the information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.

_____ _____

Signature of Requestor or Requestor's Personal Representative Date