



# Health Information Authorization Form

This form is located under the "Forms and Publications" section under Patient Protection/Privacy of Health Information.

Esta forma de autorización esta disponible en español. Llame al (800) 385-9952 o visite nuestra pagina de internet en [www.tmliebp.org](http://www.tmliebp.org) para obtener la copia en español.

You must complete Sections 1, 2, and 8. If you leave a section blank, TML IEBP cannot accept your Authorization Form.

### Your Information

Your Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
Daytime Phone #: \_\_\_\_\_

### Covered Employee Information

Covered Employee's Name: \_\_\_\_\_  
Employer's Name: \_\_\_\_\_  
Subscriber ID #: \_\_\_\_\_  
Group #: \_\_\_\_\_

I authorize TML IEBP to release or disclose my personal health information as described below:

- 1) **Who do you want to access, get or receive your personal health information?** (include name, address and/or phone number) *For example, if you want your husband or wife to have access to your personal health information, write his or her name here.*

\_\_\_\_\_

**ONLINE ACCESS:** If you want the person listed above to have online access to your claims information, he/she must be covered under a TML IEBP health plan, have his/her own *my*TML IEBP online account, AND YOU MUST PROVIDE HIS/HER SUBSCRIBER ID #.

\_\_\_\_\_

- 2) **What information do you want TML IEBP to release, give out or share?** *For example, you may want TML IEBP to give out all of your health information or you may want us to give out information only about one date of service.*

All my health information (as allowed by law)                       Other (please specify): \_\_\_\_\_

- 3) **Purpose of Disclosure:** Unless another purpose is listed here, this authorization is made at my request. \_\_\_\_\_

- 4) **Expiration:** Unless an earlier expiration date or expiration event is specified here, this authorization expires three years from the date this authorization is signed. \_\_\_\_\_

**Federal law requires that your authorization include the following information on your rights under the Privacy Rule. Please read carefully.**

- 5) You may revoke or withdraw this authorization at any time by sending a letter to TML IEBP's Privacy & Security Officer at the address below. The withdrawal does not take effect until after TML IEBP receives and logs it and does not affect information released by TML IEBP before logging your withdrawal.
- 6) If you allow the release of your health information to a person other than a health plan or healthcare provider, that person may give your information to someone else without your permission.
- 7) TML IEBP cannot make you sign this authorization as a requirement for enrolling in the health plan or for benefits eligibility.
- 8) **Your Signature and Date. I approve the use and sharing of my health information as described in this authorization.**

Your Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Please note that in the event of your death, this authorization will no longer be in effect. Only executors or court-appointed administrators have authority to receive the personal health information of deceased individuals.*

**IF SOMEONE OTHER THAN THE COVERED INDIVIDUAL SIGNS THIS FORM, SECTION 9 MUST BE COMPLETED.**

- 9) **Personal Representative Information.** If you sign this form for someone else, you must tell us about your legal right to sign. For example, if you sign for your son or daughter who is less than 18 years old, write "Parent of the minor child." If you have a medical power of attorney that allows you to make medical decisions for the individual, write "Medical power of attorney." TML IEBP may require you to send in legal papers that prove you have the right to sign for the individual. \_\_\_\_\_

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**Please mail your completed and signed form to:**

**TML IEBP  
1821 Rutherford Lane, Suite 300  
Austin, TX 78754-5151**

**Or FAX to: (512) 719-6539**