HIPAA CONSENT FORM

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides privacy protections to your medical records. Our benefits office (or other third party designated by our office) may sometimes need to disclose medical information or payment information protected by HIPAA in relation to our group health plans to your family members or close friends involved in your health care. For example, your spouse may need to contact us if you are in the hospital to determine whether a particular procedure is covered under our group health plan or may need assistance filing a claim for medical services. Under HIPAA, unless you specifically object, we are allowed to use our professional judgment in deciding whether to discuss your medical and payment information with your family members or close friends. However, we would like to provide you with the opportunity to tell us with whom we may discuss your medical or payment information under our group health plans.

Name: _____

Address: _____ Phone Number: _____

_____

□ You may communicate with the following individuals relating to my medical or payment information under the District's group health plan:

_____

_____

_____

_____

_____

□ Please do not discuss my medical or payment information with the following individuals:

_____

_____

_____

□ Please do not discuss my medical or payment information with anyone.

_____
Signature

_____
Date