COMPENSATION DEPARTMENT

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

The purpose of this Form is to permit the MCCCD Compensation Department to *communicate* **health information contained in its medical or flexible spending account benefits records, or additional and related health information that you provide, to someone else.** You must complete this authorization form each time that you seek assistance from the Compensation Department on a matter that may require the Department to speak to a third party. (Examples are family members, ex-spouses, personal representatives such as lawyers, auto or other liability insurance carriers, MCCCD employees other than those in the Compensation Department, doctors, dentists, and pharmacies.)

NOTE: *One person may not authorize the use or disclosure of another person's health information, unless that person is a minor. You may designate someone other than yourself to communicate with the Compensation Department about the matters specified on this Form. If you wish to do so, complete the Designated Representative Authorization at the end of this Form.*

Name of Authorizing Person (Print): _____

Employee ID No.: _____ **OR** Dependent SS No.: _____

I am covered under an MCCCD medical plan and am:

- ☐ An employee of MCCCD
- ☐ A spouse/partner or dependent of an employee
- ☐ A former employee, or spouse/partner or dependent of a former employee

If the Authorizing Person is not an MCCCD employee, the name of the MCCCD employee through whom the person is covered under an MCCCD medical plan:

Employee Name: _____ Employee ID Number: _____

College: _____ Department: _____ Phone: _____

If the person whose health information is to be used or disclosed under this authorization is a minor covered under an MCCCD medical plan, the name of the minor:

Name: _____ Social Security Number: _____

AUTHORIZATION

I authorize the MCCCD Compensation Department to use or disclose health information about me or the minor identified above as described below.

1. Nature of health information

- ☐ Claim and billing information
- ☐ Enrollment information or records
- ☐ Other: _____
- ☐ I am providing additional health information to the Compensation Department to assist with the matters specified in this Form. The additional health information is described below:
  - ☐ Explanation of medical benefits (EOB)
  - ☐ Medical bills or invoices
  - ☐ Other (describe): _____

PLEASE SUBMIT THIS FORM TO THE PERSON IN THE MCCCD COMPENSATION DEPARTMENT THAT YOU CONTACTED FOR ASSISTANCE.

2. Reason for use or disclosure

☐ At my request (if you do not wish to state a reason)

☐ To resolve a benefits claim:

Health Plan: _____ Dates of service: _____

Provider Name (such as doctor, pharmacy, lab): _____

☐ To resolve an issue regarding enrollment and coverage under (name medical plan):

_____

☐ To assist in dealing with:

☐ Workers' Compensation matter ☐ Auto liability/other liability matter

☐ Disability insurance matter ☐ Information pertaining to leave

☐ Other (describe): _____

3. Authorized persons or organizations for disclosure

I authorize MCCCD to disclose health information to the following persons or organizations (provide specific names in the blank spaces):

☐ MCCCD's Employment Department

☐ My supervisor or manager: _____

☐ My spouse/partner: _____

☐ A relative: _____

☐ My lawyer: _____

☐ My spouse's employer: _____

☐ MCCCD Workers' Compensation administrator

☐ MCCCD disability insurance administrator

☐ Non-medical insurance carrier: _____

☐ Provider (doctor, pharmacist): _____

☐ Other (describe and name): _____

4. Terms of the Authorization

A. I understand that, if the persons or organizations listed in Section 3 are not required to comply with applicable privacy laws, they may further disclose or use my health information and it is no longer protected.

B. I understand that I may revoke this authorization at any time in writing addressed to the benefits specialist(s) in the Compensation Department working with me on this matter. I understand that MCCCD may make certain uses and disclosures of my health information without my authorization as specified in MCCCD's privacy notice, available at:

www.dist.maricopa.edu/hrweb/health.html

Finally, I understand that my revocation cannot affect any use or disclosure of health information based on this authorization if it occurred before the appropriate benefits specialist received my revocation letter.

C. This authorization expires on [**insert date or condition**]: _____.

PLEASE SUBMIT THIS FORM TO THE PERSON IN THE MCCCD COMPENSATION DEPARTMENT THAT YOU CONTACTED FOR ASSISTANCE.

D. I understand that I do not have to sign this authorization and that my refusal to do so will not affect my eligibility for MCCCD medical benefits. I also understand that, if I do not sign it, MCCCD will not be able to disclose my health information to the person or organizations identified in Section 3 or assist in resolution of the matter specified in Section 2.

E. I acknowledge that I have been given a copy of this authorization and that I have a right to review or receive copies of the health information being used or disclosed.

Signature: _____ **Date:** _____

Please deliver, fax or mail this Form and any additional information to the MCCCD Compensation Department. The fax number is 480-731-8484. The Compensation Department must receive this Form before it will communicate with someone about your health information as specified in the Form.

NOTE: To ensure greater privacy, MCCCD's Compensation Department maintains a "lock box" at its main office into which you may place items such as this Form. If you choose to forward this Form and related documents via intercampus mail or fax, MCCCD cannot be responsible for uses or disclosures of your health care information that may occur as a result.

DESIGNATED REPRESENTATIVE AUTHORIZATION (Complete if applicable)

I authorize the following person to be my designated representative for the matter specified above to work and communicate with the Compensation Department on my behalf:

Name (Print): _____ **Relationship:** _____

I understand that this authorization expires on the date specified in Section 4-C above. I also understand that this authorization entitles the Compensation Department to communicate on this matter on my behalf with anyone who, in person or by phone, identifies himself or herself by the name specified above.

Authorizing Person: _____ **Date:** _____

PLEASE SUBMIT THIS FORM TO THE PERSON IN THE MCCCD COMPENSATION DEPARTMENT THAT YOU CONTACTED FOR ASSISTANCE.