

CITY OF LAKELAND INDIVIDUAL AUTHORIZATION FORM

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I _____ hereby authorize the use or disclosure of my health information as described in this authorization.

_____ is authorized to provide the information.
(Specific person/organization)

_____ is authorized to receive and use the information:
(Specific person/organization)

The specific description of the information is:

- (4) *Right to revoke:* I understand that I have the right to revoke this authorization at any time by notifying the City of Lakeland's Health Benefits Coordinator in writing at the Office of Risk Management, 520 North Lake Parker Avenue, Lakeland, Florida, 33801. I understand that the revocation is only effective after it is received and logged by the Health Benefit's Coordinator. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.
- (5) I understand that after this information is disclosed, federal law might not protect it and the recipient might re-disclose it.
- (6) I understand that I am entitled to receive a copy of this authorization.
- (7) I understand that this authorization will expire when my employment with the City of Lakeland terminates and for all others such as retirees on this date: _____.
M/D/Y

Signature of Employee

Date

Personal Representatives section

If a Personal Representative executes this form, the Representative warrants that he or she has authority to sign this form on the basis of:

CITY OF LAKELAND INDIVIDUAL RIGHTS FORM

INDIVIDUAL REQUEST TO INSPECT HEALTH INFORMATION

I request to review health information held about me in the City of Lakeland Employee Health Care Plan group health plan's "designated record set" in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). A "designated record set" includes information such as medical records; billing records; enrollment, payment, claims adjudication and health plan case or medical management record systems; or records used to make decisions about individuals.

I understand that the group health plan has 30 days to respond to this request, and that if someone else holds the information or it is off-site, the response time is 60 days.

I request that the information be provided in the following format: (circle one)

Paper

Electronic

Optional: I agree that the group health plan may provide a summary of the health information instead of allowing me to review the information.

I agree to pay any fees for copying or summarizing my health information. Fees will be reasonable and cost-based, and include only the cost of copying, postage, and preparation of a summary (if I agree to a summary).

I understand that this request does not apply to certain health information, including: (1) information that is not held in the designated record set; (2) psychotherapy notes; (3) information compiled in reasonable anticipation of or for litigation; and (4) other information not subject to the right to access information under HIPAA.

Signature: _____

Date: _____

CITY OF LAKELAND INDIVIDUAL RIGHTS FORMS

GROUP HEALTH PLAN'S RESPONSE TO INSPECTION REQUEST

Grant

Your request to access your health information has been granted. Access will be provided by

Need for Extension of Time

The group health plan received your request to access health information on _____. The group health plan has evaluated your request to access health information. A delay in providing the information is necessary for the following reason:

The group health plan will respond to your request within 60 days from the date of your request.

Denial of Access

The group health plan received your request to access health information and was denied for the following reason: _____

You may file a complaint regarding this decision with the group health plan or the U.S. Department of Health and Human Services. If you file a complaint with the group health plan, please file it in writing with the following person: Health Benefits Coordinator, Address: 520 N. Lake Parker Avenue, Lakeland, Florida 33801, Phone: 863-834-6795, or Fax: 863-834-6787.

In certain cases you are entitled to appeal the denial of access. You are entitled to an appeal if access was denied because in the opinion of a licensed health care professional, granting access is likely to endanger the life or physical safety of you or another person. If you appeal, your appeal will be reviewed by a licensed health care professional designated by the plan that did not participate in the original decision. The appeal and notice of the appeal decision will be conducted promptly.

Signature of Plan Representative _____ Date _____

CITY OF LAKELAND INDIVIDUAL RIGHTS FORMS

INDIVIDUAL REQUEST TO CORRECT OR AMEND A RECORD

I request the group health plan to amend the protected health information in its designated record set.

Specific Statement of Amendment Request

Specific Reason for Amendment Request

I understand that if the protected health information was not created by the group health plan, the group health plan is not required to honor my request. For example, if the information I wish to amend is in a medical report created by my physician, I must ask the physician – not the plan – to amend the report. I also understand that if the information is not available for my inspection, is not part of the plan’s designated record set or is already accurate and complete, I cannot amend the information.

I understand that the group health plan will respond to my request within 60 days.

Signature: _____

Date: _____

CITY OF LAKELAND INDIVIDUAL RIGHTS FORMS

GROUP HEALTH PLAN'S RESPONSE TO AMENDMENT OR CORRECTION REQUEST

Grant

Your request to amend or correct your health information has been granted. The Plan will make an appropriate amendment to the designated record set.

You must provide the Plan with the names and addresses of any persons to which you wish to provide the amended information. The Plan then will make reasonable efforts to inform these individuals – and persons that the Plan knows may have relied or could rely on the information – of the amendment within a reasonable time.

Need for Extension of Time

The group health plan received your request to amend your health information on _____. The group health plan has evaluated your request to amend health information. A delay in action is necessary for the following reason: _____

The group health plan will respond to your request within 60 days of your request.

Denial of Access

The group health plan received your request to amend health information on _____. Your request is denied for the following reason: _____

Statement of Disagreement

You have the right to file a written statement disagreeing with denial of amendment. The statement of disagreement must be limited to two single-sided 8-1/2 x 11 pages. The statement of disagreement should be filed within 60 days of this notice with the Health Benefits Coordinator at the Office of Risk Management at 520 N. Lake Parker Avenue, Lakeland, Florida 33801. The Plan has the right to prepare a rebuttal statement to your statement of disagreement. If it does so, you will receive a copy.

If you do not submit a statement of disagreement, you may request that the Plan provide your request for amendment and this denial of amendment with any future disclosures of protected health information that is the subject of this request.

You may file a complaint regarding this decision with the group health plan or the U.S. Department of Health and Human Services. If you file a complaint with the group health plan, please file it in writing with the following person: Health Benefits Coordinator, Address: 520 N. Lake Parker Avenue, Lakeland, Florida 33801, Phone: 863-834-6795, or Fax 863-834-6787.

CITY OF LAKELAND INDIVIDUAL RIGHTS FORMS

INDIVIDUAL REQUEST NOT TO USE OR DISCLOSE HEALTH INFORMATION

I understand that the City of Lakeland group health plan may use and disclose **protected health information about me for purposes of health care treatment**, payment and health care operations without my consent. I request to restrict use and disclosure of protected health information concerning health care treatment, payment or health care operations about me by the City of Lakeland group health plan in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Group Health Plan Not Required To Agree

I understand that the group health plan is not required to agree to this restriction.

Termination of Restriction

I understand that if the group health plan agrees to this restriction, either the Plan or I may terminate this restriction at any time. The termination of the restriction is only effective for future uses and disclosures.

Emergency Treatment Exception

I understand that if protected health information must be used or disclosed to provide emergency treatment for me, then this restriction is void.

Questionnaire

Requestor: Please complete all of the following questions. If the question is not applicable, mark N/A on the answer line.

1) I request the following information be restricted: _____

2) I request that use and disclosure of the above described information be restricted in the following manner: _____

3) I request that my protected health information not be disclosed to the following individuals or entities: _____

I understand that if a restriction is not specifically listed above and agreed to in writing by the group health plan, it will not be effective.

Signature of Employee: _____

Date: _____