RELEASE OF INFORMATION TO "FAMILY"

HIPAA-COMPLIANT AUTHORIZATION FOR TIPP CUSTOMER CARE'S RELEASE OF MEDICAL AND DISABILITY CLAIMS INFORMATION (PURSUANT TO 45 CFR 164.508)

Claimant's Full Name: ____
Date of Birth: _________________
Social Security Number (last 4 digits only): xxx-xx-______
Employer's Name: ____

I authorize and request the Texas Income Protection Plan[SM] (TIPP) Customer Care to communicate information contained within medical documents, disability and leave administrative claims files and/or protected healthcare information ("**Documents**") that may be in TIPP Customer Care's custody and control and to speak with and to share that information with ____("**Recipient**") who is my ____[**choose from spouse, daughter, grandson, domestic partner, nephew, friend, etc**]. The information TIPP Customer Care is hereby authorized to share with Recipient may include, but is not limited to, Documents about my medical condition, treatment, supplies, expenses, coverage or benefits, or my employment, vocation, education, training, income, disability or ability to work, whether maintained prior to or within (1) year after the Effective Date of this Authorization.

This Authorization may include disclosure of Documents relating to treatment for **ALCOHOL, DRUG ABUSE, GENETIC DOCUMENTS, HIV RELATED DOCUMENTS, and MENTAL HEALTH CARE** except psychotherapy notes, but only if I place my initials on the appropriate lines below. In the event my Documents include any of these 5 types of Documents and I initial the line below, I specifically authorize release of the Information contained in such Documents to Recipient.

Include in my Documents (*Indicate by Initialing*):
________ **Alcohol/Drug Abuse Treatment**
________ **Mental Health Document**
________ **Sexually Transmitted Diseases (STDs)**
________ **AIDS/ HIV-Related Documents**
________ **Family & Genetic Documents**

TIPP Customer Care will tell the Recipient receiving the information that the information is confidential. I understand the HIPAA law requires that I be advised that Documents and information released to any designated Recipient may be re-disclosed by Recipient to other parties where state and federal privacy laws may not protect it.

The Purpose of allowing TIPP Customer Care to share my information and Documents with the Recipient is to allow them to ____ ("**Purpose**").
Any signed facsimile or copy of this Authorization shall authorize TIPP Customer Care to share information and my Documents for the above-stated Purpose.

This Authorization shall be in force and effect for one (1) year from date of execution, at which time this Authorization expires. If I change my mind before then, I can tell TIPP Customer Care in writing that I do not want Recipient to obtain any more information or Documents, although that will not change any actions TIPP Customer Care took before receiving my letter.

Once this Authorization is completed and signed by the claimant, it should be returned to TIPP Customer Care by fax at 1-847-554-1853 or mail to PO Box 299093, Lewisville, TX 75029-9093.

I understand that signing this Authorization is voluntary and that I have had the opportunity to consult with an attorney about signing this Authorization and all my questions about this Authorization have been answered. If I do not sign this form, it will not affect my treatment, payment, enrollment in a health plan, or eligibility for benefits.

____

Signature of Claimant Effective Date

THIS AUTHORIZATION FOR RELEASE OF RECORDS AND INFORMATION IS IN 14-PT FONT IN COMPLIANCE WITH CALIFORNIA LAW AT CAL.CIV.CODE §56.11.