PHI Consent

Protected Health Information, or PHI is health information that is created or received that relates to past, present or future physical or mental health conditions. You must consent to release your claim data to County in order to receive cash HSA Wellness Incentives or to have Healthy Lifestyles automatically credit you for wellness exams. c

County personnel will not see your diagnoses, prescription usage, genetic information, medical record, or an indication of your overall health. Health plans will provide the date you had certain wellness procedures done (e.g. the date of mammogram, PSA, colonoscopy, prenatal, dental exam or flu shot). The only indicator for your provider will be if you went the HealthyMe Employee Clinic for your routine annual exam, so you can be reimbursed the appropriate cash HSA wellness incentive.

Click HHS.gov for more information about HIPAA and PHI.

HIPAA Privacy Authorization Form

This form is an authorization for the use and disclosure of Protected Health Information as required by the Health Insurance Portability and Accountability Act ("HIPAA") Pursuant to 45 CFR §§ 160, 164

1. I authorize the health plan and all health care providers to use and disclose the Protected Health Information ("PHI") to Salt Lake County – Human Resources and Healthy Lifestyles for the purpose of administering the County's HSA Wellness Incentive and the County's Healthy Lifestyles Program.

2. This authorization releases the name, date of service, type of service, name of provider and EIN or social security number in connection with flu shot, annual exams, mammograms, prostate exams, dental annual cleaning, and other wellness services.

3. This release of PHI covers all past, present, and future period of health care.

4. This authorization shall be in force and effective until the termination of my employment or my written revocation.

5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

6. I understand that this authorization is voluntary.

7. I understand that my treatment, payment, enrollment or eligibility for coverage under the health plan will not be conditioned on whether I sign this authorization.

8. I understand that my eligibility to receive the County's HSA Wellness Incentive is conditioned upon whether I sign this authorization.

9. I understand that the information used or disclosed pursuant to this authorization may be disclosed by the County in the administration of the County's HSA Wellness Incentive and the County's Healthy Lifestyles Program's annual rebate and may no longer be protected by federal or state law.

10. I understand that the HSA Wellness Incentive for both the employee and spouse will be contributed directly into the employee's HSA.

I, _____,consent to share my health information

Print Name

_____

Signature

_____ _____

Participant ID (EIN +1) Date

Please Select:

Enrolled Health Plan:

☐ Select Health ☐ PEHP ☐ Non-SLCo Plan

Enrolled HDHP/HSA Plan:

☐ Yes ☐ No

Enrolled in SLCo Dental Plan:

☐ Yes ☐ No