PCIP Authorization to Share Personal Health Information

Use this form if you want the Federally-run PCIP to share your personal health information with other people or organizations who call PCIP on your behalf. The Federally-run PCIP is operated by the U.S. Department of Agriculture's National Finance Center, other Federal agencies, and GEHA, the PCIP benefits administrator.

1. Print Name
(first & last name of PCIP applicant/enrollee)

PCIP Account Number or PCIP ID Number (if known)

Date of Birth
(mm/dd/yyyy)

2. PCIP will only share the personal health information you agree to.

2A: Check one box below to tell us the specific information you agree to share:

- ☐ Limited Information (go to question 2B)
- ☐ Any Personal Health Information that PCIP has about me (go to question 3)

2B: If you selected "Limited Information," check which types of information you agree to share:

- ☐ Information about your PCIP eligibility
- ☐ Information about your PCIP claims
- ☐ Information about your PCIP enrollment
- ☐ Information about premium payments
- ☐ Other specific information (please write below; for example, "payment information")

_____

3. Check one box below to let PCIP know how long you agree to share your personal health information. (Subject to applicable law —for example, your State may limit how long PCIP can share your personal health information.)

- ☐ Share my personal health information two years following my disenrollment from PCIP.
- ☐ Share my personal health information for a limited period only:

beginning : _____ (mm/dd/yyyy) and ending : _____ (mm/dd/yyyy)

4. List the names and addresses of the people or organizations you want PCIP to share your personal health information with. Please provide the specific name of the person for any organization you list:

1. Name: _____

   Relationship or Organization: _____

   Address: _____

2. Name: _____

   Relationship or Organization: _____

   Address: _____

3. Name: _____

   Relationship or Organization: _____

   Address: _____

5. I give PCIP permission to share my personal health information listed on page 1 with the person(s) or organization(s) named above. I understand that my personal health information may be re-disclosed by the person(s) or organization(s) and may no longer be protected by law.

_____

Signature Phone Number Date (mm/dd/yyyy)

PCIP Applicant/Enrollee Address (Street, City, State & ZIP)

_____

_____

Are you completing this form for someone else?

☐ Check here if you're signing as a personal representative, and complete below. Unless you're the parent of a minor child, please attach documented proof that you're acting on that person's behalf (for example, Power of Attorney).

Address of Person Completing Form (Street, City, State & ZIP)

_____

_____

Phone Number: _____

Relationship to Applicant/Enrollee: _____

6. Send this ORIGINAL completed, signed form to:

PCIP
Attn: Compliance Dept.
P.O. Box 438
Independence, MO 64051-0438

7. NOTE: You Can Stop Information-Sharing at Any Time

You have the right to stop sharing your personal information at any time, although this won't affect any information that PCIP has already shared. To end your permission, send a written request to the address shown above.

PCIP won't base your treatment, payment, enrollment, or benefit eligibility on whether or not you sign this form.