

**BAE SYSTEMS North America
Organized Healthcare Arrangement
Authorization For Release of
Protected Health Information**

Instructions

If you are asked to assist a participant in resolving a health plan claim issue, you must complete this form and have the participant review and sign it before using or disclosing any protected health information revealed by the participant.

Step 1: Fill in the participant name and social security number. The participant is the person to whom the claim relates, that is, the person who received medical care. If the participant is a dependent of a BAE SYSTEMS employee or retiree, also fill in the name of the employee or retiree and his/her social security number. If the participant is a minor, the minor's parent should review this form and sign as the child's legal representative. If the minor is age 12 or older, the minor must also sign the authorization form. If the minor who is age 12 or older does not sign the authorization form, you must refer the issue to the Privacy Officer.

Step 2: List the persons or department authorized to receive or disclose the participant's protected health information. Some examples include: "HR Department", "Benefits Department", "all individuals who must receive the information in order to resolve the issue", or list specific individuals. If specific individuals are listed and the participant's protected health information must be disclosed to some other individual not listed, the participant will be required to complete another authorization form.

Step 3: List the participant's information that may be used or disclosed. Some examples include: "all information pertaining to the claim incurred on _____ (insert claim date)", "information contained on the explanation of benefits dated _____ (insert date of explanation of benefits)", "information relating to the bill for medical services dated _____ (insert date of bill)."

Step 4: Identify the purpose of the disclosure. Usually, the purpose of the disclosure will be to resolve a claim issue.

Step 5: Identify when the authorization will expire. For example, "the date the claim issue is resolved to the satisfaction of participant," or the participant may specify a date on which the authorization will expire.

Step 6: Fill in your name in the blank under first bullet in item #6. The participant may revoke the authorization prior to the expiration date by notifying you or the health plan in writing at any time. The participant must read the section entitled "Important Information About Your Rights" and sign and date the form. If the participant to whom the claim relates is a minor, the minor's parent should sign as the child's legal representative.

1. Authorization

I hereby authorize the use or disclosure of my health information as described below. *I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information.*

Participant Name: _____ S.S. Number: _____

Employee/Retiree Name: _____ S.S. Number: _____

2. Persons/department authorized to receive the information:

3. Specific description of information to be used or disclosed:

4. Specific purpose of the disclosure:

5. Expiration and Revocation: This authorization will expire _____ (indicate date or an event relating to you personally or to the purpose of the authorization). I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to _____ or the Privacy Officer at the following address:

Privacy Officer
c/o BAE SYSTEMS BenefitCenter
P.O. Box 4846
Chesapeake, VA 23327-4846

6. Important Information About Your Rights

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying _____ in writing, but the revocation will not have any affect on any actions the entity took before it received the revocation.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).
- The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving entity. I have the right to seek assurances from the above named persons/organizations authorized to receive the information that they will not redisclose the information to any other party without my further authorization.

Participant Signature

Date

Minor Participant, if age 12 or older

Date

Parent, if minor or Legal Representative

Date

Printed name of the Parent or Legal Representative

Relationship to Participant