Authorization to Disclose Information

(For telephone and correspondence inquiries about TRICARE claims, enrollment and authorizations/referrals only)

I authorize TRICARE Management Activity (TMA), Health Net Federal Services, Inc. and/or PGBA to disclose my information to a third party recipient as I designate below. Completion of this form is voluntary. If the form is not completed in its entirety, the requested information will not be disclosed to the recipient identified. This authorization is in compliance with Federal privacy regulations including the U. S. Department of Health and Human Services Privacy Rule at 45 CFR §164.508.

I authorize _____
(Print or type name and address of authorized person)

to receive information on the following:

- ❑ Information related to my medical treatment and/or payment of TRICARE claims.
- ❑ Information related to my medical treatment and/or payment of TRICARE claims specifically for the care I received from _____on the date(s) of _____.
- ❑ Alcohol and substance abuse records.* _____. *(Initial here to confirm, if applicable).

This information may include photocopies of medical records needed to adjudicate my claims for TRICARE benefits. If the purpose of this authorization is for a reason other than determining TRICARE claims payment, please describe _____.

I understand that the protected health information I have authorized to disclose may be disclosed to and/or received by persons or organizations that are not health plans, health care providers or health care clearinghouses governed by federal privacy laws such as HIPAA. I also understand that such recipients may potentially re-disclose the protected health information, and that this re-disclosure is not protected by federal health information privacy laws.

I understand that if I have not specified an expiration date or event that this authorization will expire 12 months after the date this form is received unless revoked at an earlier date by either my personal representative or myself. I understand that I may revoke this authorization any time by sending a request in writing to PGBA at this address listed below except for actions already taken in my behalf based on this authorization. I also understand that payment, enrollment, nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization. I am aware of my right to receive a copy of this authorization.

I understand that the completion of this form does not entitle the above person to act on my behalf in an appeal of a denial of TRICARE benefits.

This consent will expire _____days from the date shown below or on _____(specific date or event).
Note: This form will be effective on the date this form is received. Also, if NO expiration date or anINDEFINITE expiration date is entered above, the expiration date will be 12 months from the date this form is received.

Sponsor's Social Security Number_____

Patient's Name_____ Date of Birth_____

_____ _____
(Signature of person giving consent) (Date Signed)

_____ Current mailing address:_____
(Print name of person giving consent)

_____

If a patient's representative signs the authorization, please attach documentation of the representative's authority.

IMPORTANT:
This form grants permission for information disclosed by telephone or correspondence about authorizations/referrals, claims, and enrollment *only.* It does *NOT* permit the person to see your claims on our Web site, www.myTRICARE.com, or grant permission to make changes to your account. To grant permission for someone to see your claims information on the Web site, you must do so within your account on www.myTRICARE.com.

TRICARE Correspondence
PGBA, LLC
P.O. Box 870141
Surfside Beach, SC 29587-9741
Fax 1-888-432-7077

*This authorization will not apply to alcohol or substance abuse information unless specifically authorized above.

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