State Teachers
Retirement System
of Ohio

275 East Broad Street
Columbus, OH 43215-3771
888-227-7877
www.strsoh.org

HIPAA AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

1. I, ______________________________, ______________________
   Full name UPI

   hereby authorize the State Teachers Retirement System of Ohio Health Care Program to disclose and discuss the protected health information about me described below ("PHI") to:

   Entity/individual ______________________________

   Address ______________________________
   Street address or P.O. box number City State ZIP code

   Phone (________)______________________
   Area code

   Email address ______________________________

2. The PHI may be disclosed for the following purpose:______________________________

   ____

   ____

3. The PHI that may be disclosed is in connection with: *(Copy of insurance card, claim number, date and any other relevant information; attach documentation, if any)*______________________________

   ____

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4. This authorization shall remain in effect until:______________________________
   Expiration date/Expiration event

5. I understand that I have the right to revoke this authorization, in writing, at any time, except to the extent that State Teachers Retirement System Retiree Health Care Program has acted in reliance upon it, by sending written notification to:

   State Teachers Retirement System of Ohio
   ATTN: Director, Health Care Services
   275 East Broad St., Columbus, OH 43215-3771

6. I understand that this authorization only applies to disclosures by the State Teachers Retirement System Retiree Health Care Program and do not authorize release of PHI from any other person or entity.

7. I understand that PHI used or disclosed pursuant to this authorization may be redisclosed by the recipient and its confidentiality may no longer be protected by federal or state law.

Signature______________________________ Date______________________

ID number______________________________