

**THE GEORGE WASHINGTON UNIVERSITY GROUP HEALTH PLAN'S  
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

I hereby authorize the use or disclosure of the protected health information (PHI) described in this authorization.

Employee Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Name of Person Receiving Services (if other than employee): \_\_\_\_\_

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1. *Person/organization/group of persons authorized to provide the information or source of information:*

- Care First Blue Cross and Blue Shield
- CIGNA
- The George Washington University Medical Reimbursement Account
- The George Washington University Benefit Services Division
- Other (*please specify*) \_\_\_\_\_

2. *Person/organization/group of persons authorized to receive and use the information:*

- The George Washington University Benefit Administration Department.
- Other (*please specify*) \_\_\_\_\_

3. *Please check below if you want the information sent to:*

- The George Washington University Benefit Administration Department.
- Other (*provide detailed information*) \_\_\_\_\_



9. *Expiration of Authorization:*

I understand that this authorization will expire when my employment with The George Washington University terminates or when my receipt of benefits from GW terminates, or earlier, if indicated below:

\_\_\_\_\_

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Signature of Employee: \_\_\_\_\_ Date: \_\_\_\_\_

PERSONAL REPRESENTATIVE (if applicable):

***NOTE:** I certify that I have the authority to sign this form on the basis of \_\_\_\_\_. I understand that I must provide a copy of any form or document that is the basis of this authority at the request of the Benefit Administration Department.*

Signature of Personal Representative: \_\_\_\_\_

Printed Name of Personal Representative: \_\_\_\_\_

Date: \_\_\_\_\_

For Plan Use Only: Date Request Received \_\_\_\_\_

By: \_\_\_\_\_

Return to:  
Division of Human Resources  
2033 K St, NW, Suite 220  
Washington, DC , 20052