

What you need to know about HIPAA



Brian Hellman

If you have been keeping up with the news lately, you probably have seen the reports regarding security data breaches, identity theft, and the benefits of staying proactive when dealing with these issues. Unfortunately, it's not a subject we like to think about or discuss, but the reality is that it does happen often, and it hits closer to home than we would like to admit. I would venture to guess that each person reading this article can name someone who has been affected by either subject.

So where are we going with this? I would like to talk about the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. As a health insurer, the NALC Health Benefit Plan always has taken care to protect our member's protected health information (PHI).

On April 14, 2003, the HIPAA Privacy Rule became effective. Under the Privacy Rule, we have adopted a notice of privacy practices. Our notice of privacy practices explains how we are allowed to use/or disclose your protected health information. We must have your authorization to use or disclose your PHI for a purpose other than to carry out treatment, payment, or health care operations; or uses permitted in our notice, unless there is an emergency situation or you are incapacitated.

If you anticipate a need to have someone assist you with your health insurance claims or questions, you must complete and return the HIPAA Privacy Rule Personal Representative Authorization form. This form allows the Plan to disclose your protected health information (PHI) to a person who will act as your personal representative.

The information covered by the authorization is protected health information, including identification of treating providers of care, diagnosis, procedures, and personal information such as date of birth and mailing address. However, please note that this authorization does not give your personal representative authority, either implied or direct, over any treatment or direct care decisions. Also, we will not condition enrollment, eligibility for benefits or

benefits payments on the completion of this form.

If you are a health benefit representative (HBR) and you have an enrollee (or several) in your branch who wants you to contact the Plan on his/her behalf to ask specific questions about claims, claim check status or detailed health information, that enrollee must fill out a Personal Representative Authorization form naming you, the HBR, as their representative.

We can and will continue to release limited claim status information only to an enrollee's spouse enrolled on the policy. We will disclose only whether a claim has been paid and, if so, on what date and in what amount. We cannot disclose any further information, such as the diagnosis or the reason for treatment without an authorization.

Members with adult children (a person generally is considered an adult at age 18) on their policy should also be reminded that under the Privacy Rule, the Plan can disclose only claim status to the natural parents of the adult child as well. For the natural parents to access a more detailed PHI, such as diagnosis and treatment of the adult child, the child must complete a Personal Representative Authorization form naming the parents as his or her personal representative.

Copies of the HIPAA Personal Representative Authorization form may be obtained by calling the Plan to request copies, or by downloading them off the NALC HBP website at nalc.org/depart/hbp. In addition, our Customer Service Department at the Plan is available to assist our members in completing these forms and by answering any questions related to the Privacy Rule. An example of the form can be seen below.

**NATIONAL ASSOCIATION OF LETTER CARRIERS
HEALTH BENEFIT PLAN**
2501 Myrtle Ave., Suite 3000 • Alexandria, VA 22304 • NALC/CRS
Kevin V. Roberts, Director • Bob E. Bellows, Scribe

**HIPAA Privacy Rule
Personal Representative Authorization**

Member # _____ Member # _____
(or a person with health insurance and Primary/Secondary Care)

SECTION A - Purpose

This form allows you (the "Individual") to give the NALC Health Benefit Plan permission (authorization) to disclose your protected health information (PHI) to a person (or persons) that you have designated as your Personal Representative. This information includes the identification of treating providers of care, diagnosis, procedures, and personal information such as your date of birth and mailing address.

Each adult family member (including each child under age 18 or older, as determined by state law), who requests to have coverage or listed as a dependent Representative must complete an authorization form. If you request your spouse to act as your health representative, you need to fill out this form. If you do not wish to request a Personal Representative, do not complete this form. You are not required to name a Personal Representative. If you do not, we will not release your protected health information to anyone who may call or write you (health, dental, financial, or other services) or to anyone who provides care to you (a spouse, parent, child, friend, caregiver, or other representative). You must indicate the authorization requested in Section C for each service. Each service that you request as your Personal Representative (if you would authorize the use of each service) must be checked on this form.

PLEASE NOTE: This authorization does not give your Personal Representative authority, either implied or direct, over any treatment or direct care decisions. Also, we will not condition enrollment, eligibility for benefits, or benefits payments on your completion of this form.

SECTION B - Individual's Acknowledgment

I understand that the NALC Health Benefit Plan is limited to the person(s) named in Section C. I am the Personal Representative(s), subject to the rights set forth in this form, if you, described in Section A.

My Name _____ Date of Birth _____
Daytime Phone _____ Relationship to Member _____

SECTION C - AUTHORIZED INDIVIDUAL'S INFORMATION

I understand that the Plan's privacy policies do not disclose my personal health information, except for the purpose of treatment, payment, or health care operations, or as required by law, without my written authorization. For this reason, I authorize you to disclose my protected health information to the person(s) named in Section B for the purpose of assisting with or facilitating the payment of my health care benefits. I have read and understand the information being disclosed by the Personal Representative(s) described in this form, the right to request and cancellation of my PHI, the right to request an accounting of disclosure of my PHI, and the right to request that I be notified of any PHI-related activity that may affect my privacy. I understand that my information may be disclosed to a health care provider, or another entity subject to federal or applicable state privacy laws, those laws may not protect my personal health information, or my Personal Representative may be able to disclose my protected health information without my authorization. I understand that my authorization is voluntary.

I understand that I have the right to limit the information you release under this authorization. For example, I may limit a Personal Representative's access to information only about a certain provider or diagnosis; or I may allow a Personal Representative access to only my stopped information from a specific provider or location for a certain time period. Any such limitations must be described in Section B in this section.

Printed Name _____ Date _____

**Privacy Official
NALC Health Benefit Plan
2501 Myrtle Court
Alexandria, VA 22304**

SECTION D - Signature/Authorization

I, _____, have had full opportunity to read and consider the content of this form. I understand that by signing this form, I am conveying my authorization that the NALC Health Benefit Plan may disclose my protected health information to the person(s) named on this form, for the purposes described above.

Signature _____ Date _____

(Signature must be the same as the name listed in Section B - Individual's Information)

Please complete and sign this form, and return it to our Privacy Official at the address shown in Section D. A pre-addressed envelope is enclosed for your convenience. We are attached to a copy of this completed form.