TEACHER RETIREMENT SYSTEM OF TEXAS
PO Box 149676, Austin, Texas 78714-0185
Telephone 1-888-237-6762 www.trs.texas.gov

TRS 628
08-18

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

NOTICES

I understand and agree to the following:

1. I have the right to receive a copy of this authorization form after I sign it.

2. As a general rule, TRS may not require me to sign this authorization as a condition of enrolling in a health plan offered under TRS-Care or TRS-ActiveCare, or being eligible for benefits under TRS-Care or TRS-ActiveCare. *However,* TRS may condition my enrollment or eligibility upon a signed release if TRS needs the information (other than psychotherapy notes) to make enrollment or eligibility determinations related to me, or to make underwriting and/or risk rating determinations. If I refuse to sign this authorization, TRS may not be able to make or obtain these determinations.

3. I have the right to revoke this authorization at any time and prevent future releases of my confidential health information, *except* to the extent that (a) I provided the authorization as a condition of obtaining health care coverage, and the law allows the payor to contest the coverage or a claim under the coverage; *or* (b) TRS has already used or disclosed my health information in reliance on the authorization. A revocation must be in writing, clearly identify the authorization I am revoking, and be signed by me or a person authorized to sign on my behalf. I must submit my written revocation request to the mailing address listed at the top of this form.

4. If I sign this authorization and TRS discloses my health information, the person or entity to which TRS discloses it may re-disclose the information without telling TRS or me, or asking for permission from TRS or from me. If this occurs, my confidential health information may no longer be protected by federal or state privacy laws.

Reverse of
Form TRS 628
08-18

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____ , TRS Participant ID No. _____ *
(your name)

hereby authorize the Teacher Retirement System of Texas, in its capacity as trustee of the Pension, TRS-Care and/or TRS-ActiveCare, its employees, and agents to use and/or disclose protected health information ("PHI") about me as follows:

1. Person (name) or class of persons who may use the PHI or to whom TRS may make the requested disclosure (name of person or company to use or receive information and their address, including street address, city, state, and zip code):
   _____
   _____
   _____

2. PHI that TRS may use or disclose (please describe specifically the information you are authorizing to be released):
   _____
   _____
   _____

3. Purpose of the authorized use or disclosure (you may state "at my request" if you do not wish to identify a particular purpose):
   _____
   _____
   _____

4. Expiration date or event (please list a specific date or a specific event when you want this authorization to terminate): _____

I HAVE READ, AND I UNDERSTAND, THE STATEMENTS ON THE REVERSE PAGE.

_____
Signature of person authorizing release Date

If a representative is signing this authorization, please describe your authority to act for the individual and attach any authorizing documents, such as a power of attorney or a court order granting guardianship:

_____

* If you do not have your Participant ID Number, please contact TRS for this information at (800) 223-8778.