Pacific Gas and Electric Company

Authorization for Use and/or Disclosure of Personal Health Information

Form Received By _____ Date _____

1. Employee/Retiree Name	1a. Employee/Retiree PERNO
1b. Employee/Retiree Date of Birth	
2. Name of Person Whose Health Information is the Subject of this Authorization	2a. Relationship to Employee Self ☐ Spouse ☐ Child ☐ Other ☐
3. Your Name	3a. Authority If you are not the person in Box 2, please describe your authority to act on his or her behalf:
4. Mailing Address for Records	4a. City, State, Zip Code

I hereby authorize The Pacific Gas and Electric Company Health Care Plan for Active Employees, The Pacific Gas and Electric Company Health Care Plan for Retirees and Surviving Dependents, and Pacific Gas and Electric Company Health Care Flexible Spending Account Plan (collectively, "Health Plan") to use and/or disclose the health information described in Sections A – E below.

Section A: Health Information to be Used and/or Disclosed

Specify the health information to be released and/or used, including (if applicable) the time period(s) to which the information relates. Select only one (1) of the following boxes:

☐ All of my past, present or future health claims and/or medical records.

☐ All of my health information relating to Claim Number _____or care rendered on _____.

☐ Other (please specify): _____

Section B: Person(s) Authorized to Use and/or Receive Information

Specify the persons or entity authorized to use and/or receive the health information described in Section A:

_____

Section C: Purposes for Which Information will be Used or Disclosed

Specify each purpose for which the health information described in Section A may be used or disclosed. Select all of the applicable boxes below:

☐ To facilitate the resolution of a claim dispute.

☐ As part of my application for leave of under the Family and Medical Leave Act (FMLA) or state family leave laws.

☐ At my request.

☐ Other (please specify):_____

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Section D: Expiration of Authorization

Specify when this Authorization expires. (Provide a date or triggering event related to the use or disclosure of the information.)

☐ On the following date: _____.

☐ Upon the passage of the following amount of time: _____.

☐ Upon my disenrollment from Pacific Gas and Electric Company's health plan.

☐ Upon my return from FMLA leave.

☐ Other (please specify): _____

_____

Your rights:

- The Plan may not condition my treatment, payment, enrollment, or eligibility for benefits upon whether I sign this authorization.
- You can revoke this Authorization at any time by submitting a written revocation to the PG&E HIPAA Administrator at the following address PG&E Benefits Department, 1850 Gateway Blvd., 7th Floor, Concord, CA 94520
- A revocation will not apply to information that has already been used or disclosed in reliance on the Authorization.
- Once the information is disclosed pursuant to this Authorization, it may be redisclosed by the recipient and the information will no longer be protected by HIPAA.
- You will be provided with a copy of this Authorization Form, after signing, if the Plan sought the Authorization.

_____ _____

Signature Date

Pacific Gas and Electric Company

Instructions for the Individual Completing this Authorization to Use and/or Disclose Personal Health Plan Information Form

- The Pacific Gas and Electric Company Health Care Plan for Active Employees, The Pacific Gas and Electric Company Health Care Plan for Retirees and Surviving Dependents, and Pacific Gas and Electric Company Health Care Flexible Spending Account Plan (collectively, "Health Plan") cannot use or disclose your health information (or the health information of your children or other people on whose behalf you can act) for certain purposes without your Authorization. This form is intended to meet the Authorization requirement.
- You must respond to each section, and sign and date this form, in order for the Authorization to be valid.
- If you wish to authorize the use and/or disclosure of any notes the Health Plan may have that were taken by a mental health professional at a counseling session, along with other health information, you must complete one (1) form for the counseling session notes and one (1) separate form for other health information.
- The sample responses given for each section below are not exhaustive and are meant for illustrations only. Under HIPAA, there are no limitations on the information that can be authorized for disclosure.

Section A: Health Information to be Used or Released. Describe in a specific and meaningful way the information to be used or released. Example descriptions include medical records relating to my appendectomy, my laboratory results and medical records from **[date]** to **[date]**, or the results of the MRI performed on me in July 2012.

Section B: Person(s) Authorized to Use and/or Receive Information. Provide a name or specific identification of the person, class of persons, or organization(s) authorized to use or receive the health information described in Section A.

Section C: Purpose(s) for which Information will be Used or Released. Describe each purpose for which the information will be used or released. If you initiate the Authorization and do not wish to provide a statement of purpose, you may select "at my request."

Section D: Expiration. Specify when this Authorization will expire. For example, you may state a specific date, a specific period of time following the date you signed this Authorization Form, or the resolution of the dispute for which you've requested assistance.

Signature Line. If you are authorizing the release of somebody else's health information, then you must describe your authority to act for the individual.