Alabama Department of Public Health
Wellness Division
Authorization for Disclosure of Protected Health Information

The Alabama Department of Public Health, Wellness Division, can send a copy of your Public Education Employees Health Insurance Program (PEEHIP) screening form or Influenza vaccine administration form if you complete all of the information below **AND** if that information matches the eligibility information provided by PEEHIP.

PLEASE SEND REQUEST TO:

APDH Wellness Program
201 Monroe Street, Suite 986
Montgomery, AL 36104
Ph: (334)206-9437 or 1-844-842-2954
Fax: (334)206-0385 or (334)206-0394

Member's Name:	Date of Birth: (mm/dd/YYYY)		SSN: (last four)
Address:			
City:	State:	Zip Code:	Telephone Number:

Purpose of this Disclosure of my Protected Health Information (select one)**:**

- ☐ At the request of the insured individual
- ☐ Other (please specify)_____

FORM REQUESTED:		**YEAR(s) REQUESTED: If not indicated, the most recent form will be sent**
	PEEHIP Screening	
	PEEHIP Influenza Vaccine Form	

I, _____ authorize the disclosure of my Protected Health Information to the following:

Name: _____ Telephone number: _____
Address: _____
City: _____ State: _____ Zip code: _____

Date of Expiration of this Authorization (select one)**:**
If no expiration date is indicated, this authorization will expire in 90 days from the date of this authorization.

- ☐ Expiration date _____

By signing this authorization, I understand that my Protected Health Information (PHI) described herein may be redisclosed by the person(s) I have authorized to receive and use my PHI and that my PHI described herein may no longer be protected by federal privacy laws. I understand that I may revoke this authorization at any time by giving written notice of my revocation to an address listed above. I understand that revocation of this authorization will not affect any action taken in reliance on this authorization before you receive my written notice of revocation.

Signature: _____ Date: _____

Printed Name: _____ Relationship to Member: _____

If signed as a Personal Representative, you must provide documentation of your authority to act as the Personal Representative of the individual who is the subject of the Protected Health Information described in this authorization (e.g., Parent, Power of Attorney, Guardianship, or Conservatorship).

Official Use Only

Received by _____ Processed by _____

Reviewed by _____ Log # _____

Revised 11/2022