Healthcare Privacy

HIPPA (Health Insurance Portability and Accountability Act) Privacy

AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION (PHI)

1. BY SIGNING THIS AUTHORIZATION FORM YOU AGREE THAT GORDMANS INC. EMPLOYEE HEALTHCARE PLAN, GORDMANS INC. FLEXWISE PLAN AND THE EMPLOYEE ASSISTANCE PROGRAM MAY USE OR DISCLOSE ANY INFORMATION RELATED TO TREATMENT, PAYMENT, ENROLLMENT OR CLAIMS FOR:
   Any individual who affixes their signature to this form
   Explanation of Plan benefits
   Claims appeal procedures and understanding of rights under the Plan
   The purpose of assisting in the adjudication of claims
   Determination of proper payment under the Plan of benefits

2. BY SIGNING THIS AUTHORIZATION FORM YOU AGREE THAT GORDMANS INC. EMPLOYEE HEALTHCARE PLAN, GORDMANS INC. FLEXWISE PLAN AND THE EMPLOYEE ASSISTANCE PROGRAM OR ITS BUSINESS ASSOCIATES MAY DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) TO:
   Any other individual who has placed their signature on this form
   Any independent third party who has a specific responsibility for claims management
   The sponsor of your Plan for administration purposes only
   Any medical provider who is providing treatment to you or to an individual listed below
   Any entity involved with health care operations (including stop-loss insurance and underwriting) or adjudication under the Plan
   Any governmental or quasi-governmental unit who has reason to request such information

3. BY SIGNING THIS AUTHORIZATION FORM YOU UNDERSTAND PHI MAY INCLUDE, BUT IS NOT LIMITED TO, THE FOLLOWING:

Medical records	Hospital records (including nurse's records and progress notes)
Emergency care records	Personal or medical information related to the purpose of this authorization form
Billing Statements	Genetic testing
Diagnostic imaging reports	Mental health (excluding psychotherapy notes)
Transcribed hospital reports Laboratory reports	HIV/AIDS
Dental records	Prescription medication
Pathology reports	Pregnancy/maternity
Physical therapy reports	Organ transplants
Explanation of benefits	Chemical dependency (including alcohol and drug treatment)

BY SIGNING THIS AUTHORIZATION you acknowledge that you have been provided a copy of and have read and understood Gordmans Inc. Employee Healthcare Plan, Gordmans Inc. Flexwise Plan and the Employee Assistance Program has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available from Gordmans Inc. Employee Healthcare Plan, Gordmans Inc. Flexwise Plan and the Employee Assistance Program at any of its offices or by writing to 1926 South 67th St Omaha NE 68106.

You have the right to revoke this authorization, in writing, at any time but the revocation will not have any effect on actions Gordmans Inc. Employee Healthcare Plan, Gordmans Inc. Flexwise Plan and the Employee Assistance Program takes before it receives the revocation. A revocation is effective upon receipt by Gordmans Inc. Employee Healthcare Plan, Gordmans Inc. Flexwise Plan and the Employee Assistance Program of a written request to revoke and a copy of the executed authorization form to be revoked, at the address listed above.

Healthcare Authorization

Important instructions regarding the completion of the authorization form.

You are not required to submit an authorization form. Submit one only if you want us to share your Protected Health Information (PHI) with someone else. You are not required to sign this form to enroll or to receive Plan benefits offered by Gordmans Inc.
Remember to date and sign your name. Remember to fill out the authorization form completely, including all address information, in the spaces provided. Please make a copy of the authorization form for your records. Return the authorization form to the Benefits Department.

Note: If you do not sign this authorization form, you will have limited access to assistance from the Benefits Department in obtaining PHI.

Acknowledged and Agreed to by

Associate Information

_____

Signature Print Name

_____

SSN Date

_____

Address City State Zip

Spouse

_____

Signature Date Print Name

_____

Address City State Zip

Adult Children (over age 18)

1.

_____

Signature Date Print Name

_____

Address City State Zip

2.

_____

Signature Date Print Name

_____

Address City State Zip

This authorization shall expire upon the earlier occurrence of a) revocation of the authorization, b) a finding by the Secretary of the US Department and Human Services, Office of Civil Rights that authorization is not in compliance with requirements of HIPPA, c) complete satisfaction of the purposes for which this authorization was originally obtained to be determined in the reasonable discretion of Gordmans Inc. Employee Healthcare Plan, and the Employee Assistance Program, or d) the date you cease to be a covered participant under any of these Plans. If you have any questions, please contact the Privacy Officer or the Benefits Department at 1-800-456-7463.