

THE GOODYEAR TIRE & RUBBER COMPANY

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of my Protected Health Information as specified below.

(Please print legibly, See reverse side for instructions.)

1. PATIENT INFORMATION

Name of Patient *(please print)* _____

Social Security Number _____

2. EMPLOYEE/RETIREE INFORMATION *(if different)*

Name of Employee/Retiree *(please print)* _____

Social Security Number _____

3. INFORMATION TO BE RELEASED

Any Relevant: Medical Plan Information Enrollment Information Dental Plan Information

Only these Specific Records: _____

Purpose for this disclosure: _____

4. NAME OF ORGANIZATION THAT HAS THE INFORMATION

Goodyear Benefits Department	<input type="checkbox"/>	Express Scripts	<input type="checkbox"/>
United Health Care	<input type="checkbox"/>	Delta Dental	<input type="checkbox"/>
Anthem Blue Cross/Blue Shield	<input type="checkbox"/>	Anthem Benefit Administrators	<input type="checkbox"/>
Cole Managed Vision	<input type="checkbox"/>	(For Salaried Medicare Only)	
Other organization: <i>(please specify)</i> _____			

5. PERSON(S) AUTHORIZED TO RECEIVE THE INFORMATION

Name(s) or title(s) of individual(s) authorized to receive this information: _____

Address _____

Phone number _____ Fax number _____

6. EXPIRATION DATE OR EVENT

I want this authorization to expire: In two years Upon termination of enrollment in the health plan

On another date or event *(please specify)* _____

7. PATIENT'S ACKNOWLEDGEMENT AND SIGNATURE

I understand that

- This authorization becomes effective when recorded by the organization;
- This authorization is voluntary;
- I will not be giving up any rights to my health plan coverage if I do not sign this authorization;
- I may revoke this authorization at any time by completing the Revocation section on this or another form, but it will not have any effect on any disclosures made before the revocation is received and recorded; and
- Information used or disclosed in connection with this authorization may be subject to re-disclosure by the recipient and no longer protected.

Patient's signature _____ Date signed _____

REPORTING OF PERSONAL REPRESENTATIVE INFORMATION

I previously designated the person named below to act legally in my behalf in matters concerning the group health plan. My Protected Health Information may be disclosed to this person. Attached is a copy of a document that shows that this person is legally permitted to act as my Personal Representative.

Name of Personal Representative _____ Relationship _____

Address of Personal Representative _____

Phone number of Personal Representative _____

REVOCAION OF AUTHORIZATION

I previously completed an authorization on _____ *(date)*

for _____ *(person authorized)*, and now want to revoke it.

Name of patient _____ Social Security Number _____

Patient's signature _____ Date signed _____

Instructions for
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Use this form to authorize a person to receive a disclosure of Protected Health Information about you concerning the Company health benefits plan. The Health Insurance Portability and Accountability Act (HIPAA) requires that this form be completed when you want to give another person permission to find out information about you under a health benefits plan.

- Step 1. Fill out the *Patient* information. The *patient* is the Individual who the information (such as medical claims and enrollment) is about.
- Step 2. Fill out the *Employee/Retiree* information if the Patient and the Employee/Retiree are not the same person.
- Step 3. Check the box for the type of information to be released. *Medical Plan Information* includes: medical care services; prescription drug; mental health and substance abuse; and vision care benefits. *Enrollment Information* concerns the eligibility records kept in the Akron Benefits Eligibility Department. *Dental Plan Information* is information maintained by the dental plan administrator.

Note: Any relevant information within the appropriate area(s) as indicated by your check mark(s) will be released. If you only want to release specific information within an area (*Medical , Enrollment and/or Dental information*) do not check the boxes, instead , print the specific information that you are authorizing to be released on the line indicated as *Only these specific records*.

Fill in the line that asks for the *Purpose*, or the reason, for this disclosure.

- Step 4. Check the box or specify the organization that has the information that you want disclosed.
- Step 5. Fill out the information about the person(s) to whom you want your information disclosed.
- Step 6. Check the box or specify when you want this authorization form to expire in the *Expiration Date or Event* section.
- Step 7. Read the acknowledgement and sign and date the form in the Patient's Acknowledgement and Signature section.
- Step 8. Obtain a copy of the executed authorization for your records.

REPORTING OF PERSONAL REPRESENTATIVE INFORMATION

Complete the *Personal Representative Information* section **ONLY** if you have already legally designated someone to act as your Personal Representative in medical benefits-related matters. If you have given someone a Power Of Attorney, Medical Power of Attorney, or some other legal authority to act in your behalf, you may choose to have this person receive the disclosure of the information. Be sure to attach a copy of the legal document that provides this authority unless you are sure that the organization that you listed in Step 4 already has a copy of this document.

REVOCAION OF AUTHORIZATION

Complete the *Revocation of Authorization* section **ONLY** if you want to revoke a previous Authorization for Release of Information. If you want that authorization cancelled prior to the expiration date, then fill out this section. Note that the revocation will not have an effect on any disclosures made prior to the receipt and recording of this form by the organization listed in Step 4.

Return the completed form to the organization listed in Step 4.

The Goodyear Tire & Rubber Co
Benefits Eligibility Dept 609
1144 E Market St.
Akron, OH 44316
Fax: (330) 796-8284

United Health Care
P O Box 30555
Salt Lake City, UT 84130
Fax: (801) 567-5499

Express Scripts, Inc.
Attn: Naomi Wenzel, Acct Mgr
6625 West 78th St., BL0340
Bloomington, MN 55439
Fax: (952) 837-7108

Anthem BC/BS
Goodyear Dedicated Unit
220 Virginia Avenue
Indianapolis, IN 46204
Fax: (317) 287-7400

Anthem Benefit Administrators
Goodyear Dedicated Unit
1801 Watermark Drive
Columbus, OH 43215
Fax: (614) 880-3120

Delta Dental
Attn: Jean Warner
2500 Corporate Exchange, Suite 230
Columbus, OH 43231
Fax: (614) 890-1274

Cole Vision

Attn: Privacy Office
1925 Enterprise Parkway
Twinsburg, OH 44087 Fax: (800) 395-1750

For other organizations, please use the address that appears on your health plan ID card.