Walmart, Inc. Associates' Medical and Dental Plan – HIPAA Authorization Form

Participant Release of Protected Health Information

Participant Carrying Coverage Information

Name _____

Date of Birth _____

State where Participant lives _____

Identification Number _____ WIN _____

Participant Whose PHI is Being Released

Name _____

Date of Birth _____

Address _____

Telephone Number _____

AUTHORIZATION (The third party who will receive the participant's Protected Health Information)
I authorize the Walmart Inc. Associates' Medical Plan and Dental Plan (the Plan), and its business associates to release Protected Health Information (PHI) to the people, group, or organization listed below:

Full Name _____ Date of Birth (if available) _____
(person, group, organization other than self)

Address _____
(person, group, or organization address needed for verification purposes)

I authorize the Plan to release: (only mark one)

◯ All my PHI or ◯ All my PHI except: _____

If you have marked except, list the information (treatment for the dates of service, diagnosis (es)/condition(s), and/or treatment by the following provider(s) name/address) that you do not want released: (Attach additional pages if necessary)

REASON FOR REQUEST:

You may check the box below that states "At participant's request" or you may specify below the reasons you are authorizing the Plan to share your PHI.

◯ At the participant's request ◯ Other reasons (specify) _____

SIGNATURE

I understand that:

- This authorization is valid for one (1) year from the date of my signature.
- I have the right to cancel this authorization at any time by completing a Cancellation of Authorization Form.
- My written cancellation will not affect the ability of the Plan to use or disclose my PHI to the extent that it has already acted on reliance on this authorization.
- I hereby authorize the use or disclosure of the PHI described in this authorization. I understand that if the person or entity that receives my PHI is not required to comply with the federal privacy regulations, the information would no longer be protected by those regulations.

I understand that payment of my claims, my ability to enroll in the Plan or be eligible for benefits is not conditioned on my signing this authorization.

_____ _____

Participant's Signature (This is the Person whose PHI will be released) Date

If you are authorizing the release of your own information, you are finished and it is not necessary to complete the below. If you have completed this form as a legally recognized representative of the participant it is necessary to complete the following:

Name of Representative (Please print your name) _____

State your relationship to the participant (That allows you to act on their behalf) _____

_____ _____

Representative's Signature (Sign this form on behalf of the participant) Date

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Plan will obtain avalid, signed authorization from a Plan participant prior to using or releasing the participant's Protected Health Information, unless the Plan participant's authorization is not legally required by law.

Return Form to:
Mail Stop 3610 - Benefits Total Rewards Team
Attn: HIPAA Compliance Team
508 SW 8th St.
Mail Stop: 3610
Bentonville, AR 72716-3610