# Protected Health Information (PHI) Authorization Form

## Health Insurance Portability and Accountability Act (HIPAA)

Bowling Green Station • P.O.Box 707 • New York, NY 10274
Tel: (212) 306-7290 • (888) 4000-MBF (outside NYC) • TTY: (212) 306-7629 • Fax: (212) 306-7353

### I. *Employee Information:*

LAST NAME | FIRST NAME | M.I. | SOCIAL SECURITY NUMBER - -

HOME ADDRESS NUMBER AND STREET | APT.

CITY | STATE | ZIP CODE + FOUR +

DATE OF BIRTH / / | HOME PHONE NUMBER - - | WORK PHONE NUMBER - - | MOBILE TELEPHONE NUMBER - -

AGENCY NAME

### II. *Specific person/organization (or class of persons authorized to receive and use PHI:*

1. HEALTH CARE CARRIER
2. HEALTH CARE CARRIER
3. HEALTH CARE CARRIER
4. HEALTH CARE CARRIER
5. HEALTH CARE CARRIER
6. OTHER (SPECIFY)

### III. *Individuals granting authorization to release PHI: (if there are additional individuals, please attach a separate piece of paper.)*

Relation to employee: (S)- Self; (SP)- Spouse; (DP)- Domestic Partner; (CO)- Child Over 18; (CU)- Child Under 18. (Check one)

| | LAST NAME | FIRST NAME | S | SP | DP | CO | CU |
|---|---|---|---|---|---|---|---|
| 1. | | | | | | | |
| 2. | | | | | | | |
| 3. | | | | | | | |
| 4. | | | | | | | |
| 5. | | | | | | | |
| 6. | | | | | | | |

### IV. *Specific description of the infomation*

**Medical, Dental, Vision claims forms for the purpose of processing by the Employee Benefits Program.**

### V. *Acknowledgement and Right to Revoke*

I hereby authorize the Employee Benefits Program to provide and disclose PHI to the above-named Health Care Carriers and/or individuals. I understand that this authorization will apply to all subsequent transactions until an effective revocation. I understand that I have the right to revoke this authorization at any time by notifying the Management Benefits Fund in writing at 22 Cortlandt Street, 28th Floor, New York, NY 10007. I understand that such revocation is only effective after it is received by the Employee Benefits Program. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation. I understand that after this information is disclosed, federal law might not protect it and the recipient might redisclose it. I understand that I am entitled to receive a copy of this authorization. I understand that this authorization will expire when my employment with the City terminates.

### VI. *Signature of dependent(s)* (**NOTE** - The employee will be deemed the personal representative of the minor dependent child.)

| SIGNATURES | DATE |
|---|---|
| 1. SIGNATURE OF EMPLOYEE | / / |
| 2. SIGNATURE OF SPOUSE OF EMPLOYEE | / / |
| 3. SIGNATURE OF EMPLOYEE DOMESTIC PARTNER OF EMPLOYEE | / / |
| 4. SIGNATURE OF DEPENDENT (OVER 18 YEARS) | / / |
| 5. SIGNATURE OF DEPENDENT (OVER 18 YEARS) | / / |
| 6. SIGNATURE OF DEPENDENT (OVER 18 YEARS) | / / |

If there are any additional signatures, please attach a separate piece of paper.