



HIPAA AUTHORIZATION FORM

Member Name: _____ EBF ID# _____

Applicant Name: _____

*The **Applicant** is the individual authorizing the release of their Protected Health Information to a Third Party

TO BE COMPLETED BY APPLICANT

A. Please indicate the type(s) of protected health information that you wish to authorize the CSEA Employee Benefit Fund to use or disclose:

Dental _____ Vision _____ Misc. Benefits _____

B. Please indicate the name and date of birth of the person(s) that you are authorizing the CSEA Employee Benefit Fund to release this information to:

Name _____ Date of Birth _____
Name _____ Date of Birth _____
Name _____ Date of Birth _____

C. I understand that I may revoke this Authorization at any time except to the extent that action has already been taken in reliance upon it. If I do not revoke it, this Authorization will expire two (2) years after the date on which the Authorization is signed. To revoke the Authorization, I understand that I must contact the following in writing:

CSEA Employee Benefit Fund
c/o HIPAA Privacy Officer P.O. Box 516
Latham, NY 12110

D. Authorization and Signature: I authorize the release of my confidential protected health information as described in my directions in Section B. I understand that this authorization is voluntary, that the information to be disclosed is protected by law and the use/disclosure is to be made to conform to my directions. I understand that this protected information may be subject to re-disclosure by a third party and hence no longer protected. **I have read the contents of this Authorization and I confirm that the contents are consistent with my directions. I understand that by signing this form, I am authorizing the use and/or disclosure of my confidential protected health information.**

Applicant Signature

Date

Signature of Witness

Date

Complete, sign and return this form to:
CSEA Employee Benefit Fund P.O. Box 516 Latham, NY 12110