



HIPAA AUTHORIZATION FORM

A. Member Name \_\_\_\_\_ ss# \_\_\_\_\_

B. 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 \_\_\_\_\_ Other \_\_\_\_\_ Describe \_\_\_\_\_

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 _____
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:

HIPAA Privacy Officer  
CSEA Employee Benefit Fund  
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.

\_\_\_\_\_  
Your Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

Complete, sign and return this form to:

CSEA Employee Benefit Fund  
P.O. Box 516  
Latham, NY 12110

