CSEA Employee Benefit Fund

HIPAA Authorization Form



The CSEA Employee Benefit Fund requires a signed HIPAA waiver from all persons 18 and older in order for the EBF to release that individual's protected health information (PHI) to a third party.

TO BE COMPLETED (PLEASE PRINT)	
Member's Name	EBF ID#
Applicant Name*	Date of Birth
*The Applicant Name 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 i	information that you wish to authorize the CSEA Employee Benefit Fund to use or disclose:
Dental	Vision Miscellaneous Claims Benefits
B. (Name of Applicant)	hereby authorize the CSEA Employee Benefit Fund to release my information to:
Name	Date of Birth
Name	Date of Birth
Name	Date of Birth
	ion at any time. This Authorization will remain in effect until revoked by the Applicant or upon revoke Authorization, I understand that I must contact the following in writing:
	CSEA Employee Benefit Fund c/o HIPAA Privacy Officer
	PO Box 516
	Latham NY 12110-0516
Section B. I understand that this authorization is to be made to conform to my directions. I understand the conform to my directions. I understand the conformation is to be made to conform to my directions.	the release of my confidential protected health information pursuant to my directions in soluntary, that the information to be disclosed is protected by law and the use/disclosure derstand that this protected information may be subject to redisclosure by a third party and ents of this Authorization and I confirm that the contents are consistent with my directions. Thorizing the use and/or disclosure of my confidential protected health information.
Signature	Date
	MAIL COMPLETED FORM TO:
	CSEA Employee Benefit Fund PO Box 516 Latham NY 12110-0516