



Protected Health Information (PHI) Authorization Form Health Insurance Portability and Accountability Act (HIPAA)

40 Rector Street, Third Floor, New York, N.Y. 10006

Tel: (212) 306-7760

- Please Print -

I. Employee information:

LAST NAME:		FIRST NAME:		SOCIAL SECURITY #:	
ADDRESS:		CITY:		STATE:	ZIP:
DATE OF BIRTH:	HOME TELEPHONE: ()		WORK TELEPHONE: ()		
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. OTHER (SPECIFY):
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.

NAME	RELATION TO EMPLOYEE	NAME	RELATION TO EMPLOYEE
1.		4.	
2.		5.	
3.		6.	

IV. Specific description of the information:

<u>Medical, Dental, Vision claims forms for the purpose of processing by the Employee Benefits Program.</u>

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 Employee Benefits Program in writing at 40 Rector Street, 3rd Floor, New York, NY 10006. 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.)

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

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