Reset Form

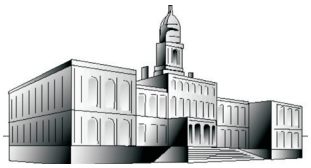
Management Benefits Fund

Protected Health Information (PHI) Authorization Form

Health Insurance Portability and Accountability Act (HIPAA)

Tel: (212) 306-7290 • (888) 4000-MBF (outside NYC) • nyc.gov/mbf

Forms and documents can be submitted electronically to: https://nyc-mbf.leapfile.net



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. I understand that such revocation is only effective after it is received by the Employee Benefits Program at https://nyc-mbf.leapfile.net. 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)	/ /

Print Form

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