Rev. 4/14

# Authorization for Use or Disclosure of Protected Health Information

Under federal law, no medical plan, hospital or physician may use or disclose certain protected health information (PHI) for uses other than treatment, payment or healthcare operations without authorization. This Authorization Form needs to be completed and signed by a Benefits Plan member, covered partner, legal guardian or other legal representative to authorize the release of PHI to the Board of Pensions.

**Please note that you only need to submit this form if medical information is needed for a Benefits Plan or Board of Pensions program other than the Medical Plan of the Benefits Plan. All sections must be completed.**

## A Whose PHI is it? *(Please print information below and check appropriate box.)*

Name SSN

Name of Legal Guardian/Representative *(if applicable)*

Address

City State ZIP Phone ( )

☐ **Benefits Plan Member** ☐ **Covered partner** ☐ **Dependent Child**

## B Name of health plan, physician, practice, hospital or healthcare provider/organization maintaining individual's medical record to be released to the Board of Pensions

*(Please check appropriate box and then complete information below.)*

☐ Health Plan ☐ Physician ☐ Hospital ☐ Other Healthcare Provider/Organization

Name

Address

City State ZIP Phone ( )

## C Recipient of medical information

I authorize the person or entity identified in Section B to release PHI to the Board of Pensions as specified below:

☐ Any Department ☐ Death & Disability ☐ Assistance Programs

☐ Other

## D Medical information to be used or disclosed

**A.** ☐ the complete medical record for services rendered on or after the following date:_____/_____/_____

**B.** ☐ only the following medical information: *(Specifically describe the information to be used or disclosed, including, but not limited to, meaningful descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc.)*

**Important note: Unless the authorization is expressly limited, this authorization grants the plan, physician, hospital, or other healthcare provider/organization the right to use or disclose all personal medical information for the purposes described, including medical information about any diagnosis or treatment for mental health, substance abuse, sexually transmitted diseases (such as HIV), cancer and/or genetic conditions.**

## E Purpose of authorization

☐ To permit the Board of Pensions to receive and use medical information from the health plan or healthcare provider identified in Section B above.

☐ Other

## F Duration of authorization

This authorization will expire on the following date:_____/_____/_____or on the occurrence of the following event:

_____

## G Right to revoke authorization

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the party identified in Section B.

## H Acknowledgement of privacy rights

**I understand that:**

- A revocation is not effective to the extent that the parties named in this authorization have relied on the use or disclosure of the protected health information prior to the receipt of the revocation;
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law; and
- My healthcare provider(s) and health plan(s) may not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits (if applicable), on whether I provide authorization for the requested use or disclosure.

**I understand that I have the right to:**

- Refuse to sign this authorization.
- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights).

**I authorize the use of a fax copy or a photocopy of this form.**

Name _____

*(Print name of Benefits Plan member, covered partner, or legal representative.)*

If legal guardian or other legal representative, please describe nature of authority by checking appropriate box below.

☐ Natural/adoptive parent

☐ Guardianship Court Order *(Please attach copy unless previously approved by the Board of Pensions.)*

☐ Power of Attorney *(Please attach copy unless previously approved by the Board of Pensions.)*

☐ Other _____

Signature _____ Date _____

*(Signature of Benefits Plan member, covered partner, or legal representative)*

## I Contact Information

- If your Board of Pensions representative directed you to send this form directly to the Board, use the address below.
- If your Board of Pensions representative directed you to send this form to your health provider, please do so and ask them to send it, along with your medical information, to us.
- If you are unsure of where to send this form, please call the Board of Pensions at the number below.

The Board of Pensions of the City of Williston
PO Drawer 160, 50 NW Main Street
Williston, Florida 32696
352-528-3060

## For Internal Use Only

**Internal Code:** _____