

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 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 information that you wish to authorize the CSEA Employee Benefit Fund to use or disclose:

Dental Vision Miscellaneous Claims Benefits

B. 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 _____

C. I understand that I may revoke this Authorization at any time. This Authorization will remain in effect until revoked by the Applicant or upon termination of enrollment in the benefit plan. To 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**

D. Authorization and Signature: I authorize the release of my confidential protected health information pursuant to 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 redisclosure 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.

Signature _____ Date _____

MAIL COMPLETED FORM TO

**CSEA Employee Benefit Fund
PO Box 516
Latham, NY 12110-0516**